

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 7 6 0
REG. NO. EDT

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ARTHUR (NMN) ADDY			2a. DATE OF DEATH MONTH DAY YEAR MAY 11, 1983			2b. HOUR 145 AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Material Ana.		12b. KIND OF BUSINESS OR INDUSTRY West. Elec.			
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11 Brownshade Dr. (21061)			
14. FATHER'S NAME FIRST MIDDLE LAST William Addy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Sharpe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT (Wife) Mrs. Adeline B. Addy		ADDRESS SAME AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive Heart Failure</u> 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis + Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic obstructive lung disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> <u>years</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-6, 19 83, to 5-11, 19 83, that (I) (we) lost saw the deceased alive on 5-11, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Sang C. DoH</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-11-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D.						22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 13 May 83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD.			
24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home, Glen Burnie, MD.						25a. DATE REC'D. BY REGISTRAR MAY 12 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE	TIME	PLACE	DESCRIPTION	QUANTITY	UNIT	VALUE	TAXES	REMARKS
1900	10:00	NEW YORK	COFFEE	100	LB	10.00	1.00	
1900	11:00	NEW YORK	TEA	50	LB	5.00	0.50	
1900	12:00	NEW YORK	SUGAR	200	LB	20.00	2.00	
1900	13:00	NEW YORK	WINE	10	GA	100.00	10.00	
1900	14:00	NEW YORK	WHISKY	5	GA	50.00	5.00	
1900	15:00	NEW YORK	BRANDY	5	GA	50.00	5.00	
1900	16:00	NEW YORK	COGNAC	5	GA	50.00	5.00	
1900	17:00	NEW YORK	CHAMPAGNE	5	GA	50.00	5.00	
1900	18:00	NEW YORK	STEWART	10	GA	100.00	10.00	
1900	19:00	NEW YORK	WINE	10	GA	100.00	10.00	
1900	20:00	NEW YORK	WHISKY	5	GA	50.00	5.00	
1900	21:00	NEW YORK	BRANDY	5	GA	50.00	5.00	
1900	22:00	NEW YORK	COGNAC	5	GA	50.00	5.00	
1900	23:00	NEW YORK	CHAMPAGNE	5	GA	50.00	5.00	
1900	24:00	NEW YORK	STEWART	10	GA	100.00	10.00	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 1 7 6 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) BERTHA Koepke ALLEN				2a. DATE OF DEATH		MONTH DAY YEAR	
				5 21 83		2b. HOUR 3:11 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
				MONTH DAY YEAR 11 28 1898		84	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MASS.		USA				ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS		AA GEN Hosp		STENOGRAPHER		SECT.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
MD. AA ANNAPOLIS				YES		22 MARYLAND AVE 91401	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
HERMAN J. KOEPKE				BARBETTA PEADENHAUER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO				016 03 2401		RONALD C. ALLEN JR. ANNAPOLIS MD 21403	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Massive Rt. sided stroke							
4331 DUE TO, OR AS A CONSEQUENCE OF (b) LT. Carotid Artery Occlusion							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (c) same							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
						PRESENT	
22a. I certify that (I) (this hospital) attended the deceased from 1978 , 19____, to PRESENT , 19____, that (I) was lost							
saw the deceased alive on 5/20 , 19 83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Sgt. E. Verkonow MD						5/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
1419 FOREST DRIVE, ANNAPOLIS MD 21403 (P.F. VERKOW)							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL				5/25/83		PITTSFIELD CENT	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Taylor Funeral Chapel - Annapolis, MD				MAY 25 1983		Joan J. Carver	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS SUSPECTED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN COPIES OF YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11762	
1. DECEASED NAME (TYPE OR PRINT) John P. Anderson						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 5 DAY 24 YEAR 1983		2b. HOUR M			
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 7 DAY 13 YEAR 43	6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 	2c. DATE PRONOUNCED DEAD MONTH 5 DAY 24 YEAR 1983		2d. HOUR 8 A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Severn River				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY LEGAL			
13a. STATE MD				13b. COUNTY A.A.		13c. CITY OR TOWN SEVERNA PK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST W.M. A. MIDDLE ANDERSON LAST ANDERSON				15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE B. LAST FORD.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216424676A		17. INFORMANT ADDRESS See 14 + 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution 9070 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 24 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject struck by lightning							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) boat		21f. LOCATION STREET Severn River CITY OR TOWN Annapolis COUNTY A.A. STATE Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 5/24/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL CREMATION REMOVAL Burial		23b. DATE 5-27-83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem		23d. LOCATION CITY OR TOWN Glen Burnie COUNTY AA STATE Ind					
24. FUNERAL DIRECTOR NAME John S. Bancroft ADDRESS Severna Pk, Ind				25a. DATE REC'D. BY REGISTRAR MAY 25 1983		25b. REGISTRAR'S SIGNATURE John S. Bancroft					

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 7 6 3

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN D. ARCHER			2a. DATE OF DEATH MONTH DAY YEAR 5-13-83		2b. HOUR MIN. 1:42 M
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3-19-18	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RHODE ISLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY WATER COMPANY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN DAVIDSONVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 626 SANTA MARIA LANE 21035
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR ARCHER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL SYLCS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-14-8711		17. INFORMANT ADDRESS CARROLL BEATTY 4316 HAMILTON ST. HYATTSVILLE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac Death 2910 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Delirium Tremens DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this physician) attended the deceased from 5/12/83 to Present , that (I) (last saw the deceased alive on 5/12/83), and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Peter F. VerKouwen		DEGREE		22c. DATE SIGNED 5/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUWEN		22e. ADDRESS 1419 FOREST DR. Annapolis, Md 21403		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/18/83	23c. NAME OF CEMETERY OR CREMATORY PINE RIDGE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CHELMSFORD MIDDLESEX MASS.
24. FUNERAL DIRECTOR NAME HARDESTY FUNERAL HOME 12 RIDGELY AVE. ANN, MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 18 1983	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 1 7 6 4 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Helen Pashley Bailey			2a. DATE OF DEATH MONTH DAY YEAR May 23, 1983			2b. HOUR A 10:30 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 6, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.					
10. CITY OR TOWN OF DEATH Odenton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 525 Saltoun Ave., Odenton MD 21113				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21113	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin D. Pashley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine W. Wasson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Son) Major Sherwood W. Bailey		ADDRESS Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrolyte depletion</u> 1539 DUE TO, OR AS A CONSEQUENCE OF <u>metastatic colon obstruction</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF <u>metastatic carcinoma of the colon</u> (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 4 months 18 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>											
19a. DATE OF OPERATION Feb 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the colon				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N.A. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N.A.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 1982</u> , 19 <u>82</u> , to <u>May 23</u> , 19 <u>83</u> , that (I) (we) lost <u>saw the deceased alive on May 1 or 2 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) (did not) view the body after death.											
22b. SIGNATURE <i>Frank Lynn Iber</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 23 May 83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank Lynn Iber, M.D.				ADDRESS University of Maryland Hospital 22 S. Greene Street, Baltimore, Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 24, 1983		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.					
24. FUNERAL DIRECTOR NAME R. H. Hopkins				ADDRESS Singleton Funeral Home, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR MAY 24 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	



CHIEF



Electrolytic deposition

Electrolytic solution deposition

4 months

10 months

Examination of the colon

Feb 1952

N.A.

N.A.

Feb 1952

May 1 or 2

May 23

82

82

23 May 52

Handwritten notes at the bottom of the page, including "May 8-1952" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 1 1 7 6 5
REG. NO. DST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LULU MAUDE BEHRENS			2a. DATE OF DEATH MONTH DAY YEAR MAY 23, 1983			2b. HOUR 10:00A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 14, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 101 Lincoln Avenue 21061	
14. FATHER'S NAME FIRST MIDDLE LAST William Liembach				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Lulu Sanford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-01-2360		17. INFORMANT ADDRESS Glen Gloria L. Hammond, 505 Dover Road, Burnie					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 <i>Coronary Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Cholelithiasis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/23 , 19 80 , to 5/23 , 19 83 , that (I) (we) last saw the deceased alive on 5/23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <i>Robert B. Kroopnick</i>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. KROOPNICK, M.D.				22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MD. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 26 May 83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD			
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR MAY 25 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>			

BP



[Faint, mostly illegible handwritten text, possibly a medical report or prescription.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director's office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 6 6

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) MARGARET A. BLACKSTONE		5/25/83		5:09 AM	
3. SEX Female	4. RACE WHITE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
		12 03 10	72 YRS	ANNE ARUNDEL MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD.	13b. COUNTY A.A.	13c. CITY OR TOWN SHERWOOD FOREST	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 106 EDGE HILL 31405	
14. FATHER'S NAME FIRST MIDDLE LAST ZACHARIAH D BLACKSTONE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARA V. WHEELER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577 10 7102		17. INFORMANT ADDRESS MRS. JOHN A MILBOURN #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Mesenteric thrombosis					
5570 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Stater Post Rt. sided Stroke & Seizure Disorder.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION	
21d. I certify that (I) (the hospital) attended the deceased from March 1983 to Present 19 that (I) (the hospital) saw the deceased alive on 5/24/83 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.					
22a. PHYSICIAN'S NAME (TYPE OR PRINT) PETER EVERKOW		22b. ADDRESS 1419 Forest Br. Annapolis Md 21403		22c. DATE SIGNED 5/25/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/26/1983		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREM.	
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL		24b. ADDRESS ANNAPOLIS MD.		25. DATE RECEIVED BY REGISTRAR MAY 27 1983	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25. REGISTRAR'S SIGNATURE John J. Carver	

MEDICAL CERTIFICATION

STATE OF NEW YORK
IN SENATE
JANUARY 11, 1903

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 11, 1903

ALBANY:
J.B. LIPPINCOTT & CO. PRINTERS
1903

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 7 6 7

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Mary F Bausum				Bausum	5-12-83					7:55 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
FEMALE	W	5-12-96		86		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore, Md.		USA				ANNE ARUNDEL MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		ANNE ARUNDEL General Hospital		Housewife		Household					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD		AAco		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2054 Riva Rd		21401	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
James Henry Farrell				Mary Belle Shank							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		218-36-3046		Evelyn Woolford		Riva Rd. Annapolis Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>5609</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>organic brain syndrome</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>5-11-83</u> to <u>5-12-83</u> , that (we) lost <u>5-11-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
G Mitchell MD								5-12-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
G Mitchell MD				205 Ridenh Ave Annapolis Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE			
Burial		5-14-83		Hillcrest		Annapolis A.A.		Md.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
T.A. Hardesty						MAY 13 1983		John J. Carver			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is required for burial or cremation.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

BP

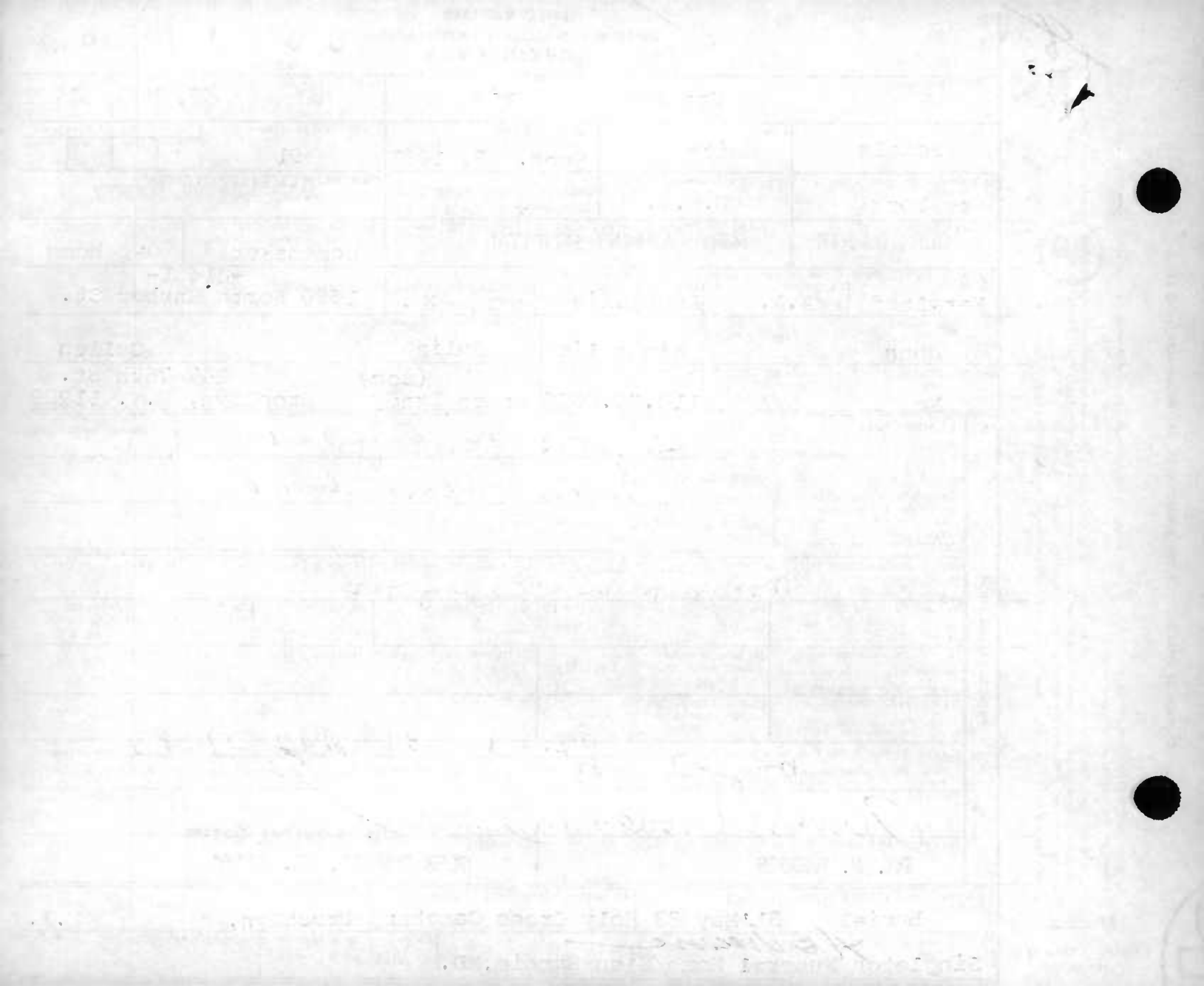


2003-2004

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		3. DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 3 1 1 7 6 8	
CERTIFICATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR
FIRST MIDDLE LAST Mary Frances Brady			MONTH DAY YEAR MAY 27, 1983		525 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR
Female	White	MONTH DAY YEAR Sept. 23, 1891	91 YRS		IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	U.S.A.		ANNE ARUNDEL COUNTY MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	GLEN BURNIE HOSPITAL		Homemaker		Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	A.A.	Annapolis	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	-21401- 1690 North Harbor Ct.	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
John Michaelis			Julia Cullen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT (Son)		ADDRESS
No		N/A	James Brady		247 76th St. Brooklyn, N.Y. 11209
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4149 IMMEDIATE CAUSE (a) Congestive Heart failure					
DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart disease					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
Malnutrition, Esophagitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 1, 1983, to May 27, 1983, that (I) (we) last saw the deceased alive on May 27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE P. Rhodes				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. P. RHODES				22e. ADDRESS 501 HOSPITAL DRIVE GLEN BURNIE, MD. 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		31 May 83	Holy Cross Cemetery		Brooklyn, N.Y.
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REGD. BY REGISTRAR		
Singleton Funeral Home/Glen Burnie, MD.			MAY 31 1983		
			25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div> <div>Item #166 Film G580 6/6/83 rc</div> <div> <div>FOR 1- STATE REGISTRAR</div> <div>8 3 1 1 7 6 9 EST</div> </div> </div>									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR	
MILDRED GLADYS BRAUN					MAY 22, 1983			0439 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
FEMALE		CAUCASIAN		MAY 6 1922		61 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		UNITED STATES				ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL				BOOK KEEPER		DRUG STORE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		ANNE ARUNDEL		SEVERNA PARK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17 MADARY RD. 21146	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
(UNKNOWN) WALKER				(UNKNOWN)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO				216-16-431 216 16-4311		JOHN W. BRAUN (SAME AS 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									
4100 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d) <u>Old pyloric ulcer. Arthritis</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>19 82</u> , to <u>19 82</u> , that (I) (we) lost <u>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.</u>			22b. SIGNATURE <u>DR. NICK MOUTSOS</u>						
22c. DATE SIGNED <u>5/23/83</u>			22d. ADDRESS <u>95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			MAY 25, 1983		CROWNSVILLE VETERAN CEM.		CROWNSVILLE ANNE ARUNDEL MD.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR SIGNATURE				
ROBERT S. BARRANCO			MAY 25 1983		JOHN J. GIBNEY				

1981

11 FEB 11 1981

100% COLLECT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 7 7 0

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST CATHERINE E. BREWER		2a. DATE OF DEATH MONTH DAY YEAR May 9, 1983		2b. HOUR M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. County MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7522 Brightwater Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7522 Brightwater Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Rothenburg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virgie Wilson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 40 4156		17. INFORMANT ADDRESS Robert L. Brewer, same as 13e					
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>72</u> , to <u>May</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Karl F. Mech, Sr., M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/11/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Karl F. Mech, Sr., M.D.		22e. ADDRESS 3350 Wilkens Ave., Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/12/1983		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME George J. Gonce, 4001 Ritchie Hgwy., Baltimore, Md.		ADDRESS Md.		25a. DATE REC'D. BY REGISTRAR MAY 11 1983		25b. REGISTRAR'S SIGNATURE <u>Joan J. Conner</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO MEMORIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11771

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		MONTH DAY YEAR	
George Woodrow C. Brightwell		5/16/85		2P	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE IN YEARS	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
MALE	WHITE	MONTH DAY YEAR	LAST BIRTHDAY	MONTHS DAYS HOURS MIN.	MONTHS DAYS HOURS MIN.
		4/15/18	65 YRS.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	9c. MARRIED	9d. NEVER MARRIED	9e. DIVORCED	9f. BALTIMORE CITY OR COUNTY OF DEATH
VIRGINIA	UNITED STATES	WIDOWED	<input checked="" type="checkbox"/>	<input type="checkbox"/>	ANNE ARUNDEL
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	12c. SOCIAL SECURITY	
ANNAPOLIS	1145 RIVERBAY RD.	SUPERVISOR		ADMINISTRATION	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	13f. ZIP CODE
MARYLAND	ANNE ARUNDEL	ANNAPOLIS	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1145 RIVERBAY RD	21401
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.	17. INFORMANT	18. ADDRESS	
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
HENRY	FLORA	225-01-6902	HENRY BRIGHTWELL	ANNAPOLIS, MD. 21401	
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	19b. SOCIAL SECURITY NO.	19c. INFORMANT	19d. ADDRESS		
YES	W.W. II				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
4360 IMMEDIATE CAUSE (a) Cerebrovascular Accident					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) Hypertension					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
George E. Richards		M.D. Deputy		MEDICAL EXAMINER 5/17/83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
George E. Richards		312 Washington St Annapolis			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. COUNTY	
BURIAL	MAY 20, 1983	BLUE RIDGE MEMORIAL GARDENS	ROANOKE	ROANOKE VA.	
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
NAME	ADDRESS				
ROBERT S. BARRANCO	501 RITCHIE HWY. SEVERNA PARK, MD.	MAY 23 1983 John J. Carney			

10/12/2011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 31 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 1 7 7 2	REG. NO.
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Margaret Elizabeth Britton					2a. DATE OF DEATH MONTH DAY YEAR MAY 18, 1983			2b. HOUR 427 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN ENOUGH SPACE, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8 Phyllis Drive (21061)			
14. FATHER'S NAME FIRST MIDDLE LAST Abel Blaney				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth McCashin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		21. INFORMANT -husband- ADDRESS same as # 13 Mr. Robert L. Britton, Sr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma unknown</u> 1629 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probably lung primary etiology</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 1 month</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>marked metastasis to liver.</u>											
19a. DATE OF OPERATION -				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>TRUNK</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>83</u> , to <u>18 MAY</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>5/19</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Lorraine M. Dailey</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-18-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORRAINE M. DAILEY, M.D.				22e. ADDRESS 8567 FORT SMALLWOOD ROAD PASADENA, MARYLAND 21122							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 21 May 83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A., MD.					
24. FUNERAL DIRECTOR NAME <u>Singleton Funeral Home</u>				ADDRESS Glen Burnie Maryland		25a. DATE REC'D. BY REGISTRAR MAY 20 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Grier</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 7 7 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) IRENE BROWN				2a. DATE OF DEATH MONTH DAY YEAR 5-18-83		2b. HOUR 7:21 AM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 25 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES DAVIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE DAVIS		13e. STREET ADDRESS 1205 Madison Street 21403			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Arnold, Md. 21012 ORA M. THOMAS 106 Marc Ct. Arnold, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST 5860 DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (b) (this hospital) attended the deceased from MAY 15 , 19 83 , to MAY 18 , 19 83 . I saw the deceased alive on MAY 17 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Barry R. Nathanson MD				DEGREE MD		22c. DATE SIGNED 5/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON				22e. ADDRESS 121 CATHEDRAL ST. ANNAP. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-21-1983		23c. NAME OF CEMETERY OR CREMATORY HOPE U.M. CHURCH CEME		23d. LOCATION CITY OR TOWN COUNTY STATE Edgewater A.A. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A.				25a. DATE REC'D. BY REGISTRAR MAY 19 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 7 7 4 REG. NO.		DST	
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
				FIRST MIDDLE LAST SAMUEL BONOM BROWN, SR.		MAY 11, 1983	
3. SEX Male				4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 16, 1895	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
10. CITY OR TOWN OF DEATH GLEN BURNIE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Berry		13d. STREET ADDRESS 676 211th. Street	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO				16b. SOCIAL SECURITY NO. 223-10-4092		17. INFORMANT ADDRESS Mrs. Neata J. Pierce (Same as 13e.)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (c) chronic obstructive lung disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-30 1983, to 5-11 1983, that (I) (we) last saw the deceased alive on 5-11 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE SANG C. DOH, M.D.				DEGREE M.D.		22c. DATE SIGNED 5-11-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D.				22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/14/83		23c. NAME OF CEMETERY OR CREMATORY Dale Memorial Park	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Chesterfield Chesterfield Va.				23e. DATE REC'D. BY REGISTRAR MAY 12 1983		23f. REGISTRAR'S SIGNATURE John J. Conner	
24. FUNERAL DIRECTOR Mc Gully Funeral Home of Pasadena Mountain and Pick Neck Rds. Pasadena, Md. 21112							

MEDICAL CERTIFICATION



Handwritten notes and a table at the top of the page. The table has several columns with headers that are difficult to read but appear to include 'Date', 'Description', and 'Amount'. There are several rows of data, some with checkmarks or 'X' marks.

Vertical text in the center of the page, possibly a date or a reference number, written in a stylized font.

Vertical text on the right side of the center, possibly a date or a reference number, written in a stylized font.



Handwritten notes and a table at the bottom of the page, similar in format to the top section, with columns for data entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
MARG.				BURR	5	6	83	7	5A
3 SEX	F.	4 RACE	Caucasian	5. DATE OF BIRTH	MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	81
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b CITIZEN OF WHAT COUNTRY?	U.S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH				
10 CITY OR TOWN OF DEATH	Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Annapolis Conv. Ctr.	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Teacher		12b KIND OF BUSINESS OR INDUSTRY	Education	
13a STATE	MD.	13b COUNTY	Annapolis	13c INSIDE CITY LIMITS?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	13d STREET ADDRESS	1024 Timber Creek Drive 21403	
14 FATHER'S NAME	Harry	15 MOTHER'S MAIDEN NAME	Willis	16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b SOCIAL SECURITY NO	214-38-5011A	17 INFORMANT	Mr. John F. Burr (Same as #13.)						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4360								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) S.P. Completed Rt Stroke								2 years	
DUE TO, OR AS A CONSEQUENCE OF (c)								7 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Seizure Disorder									
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?	YES <input type="checkbox"/>		NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 9-13-83 1973 to Present 19, that (I) (we) lost the deceased alive on 9-13-83 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (did) (did not) view the body after death.									
22b SIGNATURE Peter F. VerKouwen				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5-6-83	
22d PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUWEN				22e ADDRESS 1419 FOREST DR. Annapolis Md 21403					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b DATE 5/6/83		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		23e DATE REC'D. BY REGISTRAR MAY 11 1983	
24 FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., MD.		25a DATE REC'D. BY REGISTRAR MAY 11 1983		25b REGISTRAR'S SIGNATURE John J. Conner	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 117 JDT 6 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GARNER W BUTTRUM				2a. DATE OF DEATH MONTH DAY YEAR MAY 11, 1983		2b. HOUR 445 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 25, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY AA 13c. CITY OR TOWN Glen Burnie				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 405 O Street, S. E. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Willard Stader				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa McCall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ADDRESS Maria Buttrum, Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Brain metastasis DUE TO, OR AS A CONSEQUENCE OF (b) Small cell lung Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Chronic obstructive lung disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 10 months	
19a. DATE OF OPERATION 4/12/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal Obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-21, 1983, to 5-11, 1983, that (I) (we) last saw the deceased alive on 5-11, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Long S. Hsu M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.				22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 13 May 83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR MAY 16 1983			
				25b. REGISTRAR'S SIGNATURE John J. Carrier			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8311777		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <i>Helen Y Bynum</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>5/13/83</i>				2b. HOUR <i>10 AM</i>	
3 SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 5 20</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co</i> MD.			
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1907 Dulaney Pl. 21401</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Orfe</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Helen WEBBER Webber</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>183-16-3840</i>		17. INFORMANT ADDRESS <i>James A. Bynum same as #13</i>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>1830 IMMEDIATE CAUSE (a) Ca Ovary</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH =	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>1982</i> , 19____, to <i>5/13/83</i> , 19____, that (II) (we) last saw the deceased alive on <i>5/13/83</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>SP Watkins MD R D E. COLE</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>5/13/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>STANLEY WATKINS</i>				22e. ADDRESS <i>121 Cathedral Ave. Annapolis, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>5-14-1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood P.G. Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Robert E. Evans Annapolis, Md. 21401</i>				25a. DATE REC'D BY REGISTRAR <i>MAY 23 1983</i> 25b. REGISTRAR'S SIGNATURE <i>John J. Gair</i>					

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 3 1 1 7 7 8 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Mildred L		MIDDLE Caldwell		LAST Caldwell		2a. DATE OF DEATH MONTH DAY YEAR May 23 1983		2b. HOUR 12 ²⁰ M	
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR OCT 9 1906		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO City, MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Severna park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 674 Creek Road						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY Home Maker	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 674 Creek Rd 21146	
14. FATHER'S NAME FIRST MIDDLE LAST Jerry Green		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie (UNKNOWN)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 46 8613		17. INFORMANT ADDRESS Thomas Caldwell (Son) #707 Wydenkey Batoled City							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 6954 DUE TO, OR AS A CONSEQUENCE OF (b) Lupus Erythematosus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years 20 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic Heart disease - Mild anoma - pleurisy											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>MD APRIL 13, 19 1975</u> , to <u>MAY 23, 19 75</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>MAY 19, 19 83</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) (did not) view the body after death.											
22b. SIGNATURE J.C. Cullis MD		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-23-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. C. CULLIS		22e. ADDRESS 7-Aggs Ave Severna Park 21146									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 26, 1983		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTIMORE 21201 MD.					
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO		ADDRESS 501 RITCHIE HWY. SEVERNA PARK, MD.		25a. DATE REC'D BY REGISTRAR MAY 25 1983							



Handwritten notes and signatures at the top of the page, including a signature that appears to be "J. H. [illegible]" and some illegible text.

Handwritten notes and signatures in the middle section, including a signature that appears to be "J. H. [illegible]" and some illegible text.



Handwritten notes and signatures at the bottom of the page, including a signature that appears to be "J. H. [illegible]" and some illegible text.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 7 7 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Salvatore CAPONNETTO				2a. DATE OF DEATH MONTH DAY YEAR 5 29 83			
2. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 28, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shoe Maker		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Anne Arundel				13b. CITY OR TOWN Edgewater		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Caponnetto		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace		16. STREET ADDRESS 1621 Millstone Drive 21037			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-10-6701		17. INFORMANT ADDRESS Sharon Retallack Edgewater, Maryland			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary heart disease (c) Generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate many years many years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Squamous cell carcinoma of right lung. Diabetes mellitus							
19a. DATE OF OPERATION Not applicable		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 29, 1983 to May 29, 1983 , that (I) lost saw the deceased alive on May 29, 1983 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.							
22b. SIGNATURE Charles W. Kinzer, M.D.				DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 29, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. KINZER, M.D.				22e. ADDRESS Annapolis, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 1 1983		23c. NAME OF CEMETERY OR CREMATORY Washington National Suidland Prince George		23d. LOCATION CITY OR TOWN COUNTY STATE Maryland	
24. FUNERAL DIRECTOR NAME Robert E. Evans				24b. ADDRESS 1212 West St Annapolis Md.		25a. DATE REC'D. BY REGISTRAR JUN 2 1983	
25b. REGISTRAR'S SIGNATURE John J. [Signature]							

CARNINETTO

April 23 1903

Am. Friends (Gen. & Mrs. J. H. ...)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NICK (nmn) CARAPELLOTTI					2a. DATE OF DEATH MONTH DAY YEAR MAY 20 1983		2b. HOUR 1227 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal Mines		
13a. STATE Maryland					13b. COUNTY A.A.		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (daughter) ADDRESS Diana M. Richardson Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Maureen Kaplan</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Maureen Kaplan</u>				22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 23 May 83		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.				
24. FUNERAL DIRECTOR NAME <u>AB Singleton</u> ADDRESS _____				25a. DATE REC'D. BY REGISTRAR MAY 20 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>				
SINGLETON FUNERAL HOME/GLEN BURNIE, MD.										

BP _____



DATE: MAY 1951 TIME: 11:00 AM

TO: MR. J. E. HARRIS

FROM: MR. J. E. HARRIS

SUBJECT: NORTH AMERICAN HOSPITAL

RE: NORTH AMERICAN HOSPITAL

1. The following information was received from the North American Hospital:

2. The hospital is located at 1000 North Main Street, New York, New York.

3. The hospital is a private hospital and is not a charity.

4. The hospital is a non-profit organization.

5. The hospital is a member of the American Hospital Association.

6. The hospital is a member of the National Association of Private Hospitals.

7. The hospital is a member of the National Association of General Hospitals.

8. The hospital is a member of the National Association of General Hospitals.

9. The hospital is a member of the National Association of General Hospitals.

10. The hospital is a member of the National Association of General Hospitals.

11. The hospital is a member of the National Association of General Hospitals.

12. The hospital is a member of the National Association of General Hospitals.

13. The hospital is a member of the National Association of General Hospitals.

14. The hospital is a member of the National Association of General Hospitals.

15. The hospital is a member of the National Association of General Hospitals.

16. The hospital is a member of the National Association of General Hospitals.

17. The hospital is a member of the National Association of General Hospitals.

18. The hospital is a member of the National Association of General Hospitals.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 7 8 1 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Algot Carlson				2a. DATE OF DEATH MONTH DAY YEAR May 14, 1983			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1905		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 78 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 955 Mt. Holly Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE NY		13b. COUNTY Kings		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Carl		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Johannsdotter		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 081-10-0002	
17. INFORMANT Edward J Carlson		18. ADDRESS 955 Mt. Holly Dr. Annapolis MD 21401		19. DATE OF OPERATION 12/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Heart Failure	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/9 P.M. 19 83	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Myocardial Infarction		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 12/9		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 16 Murray Ave, Annapolis MD 21401	
22a. I certify that (I) (this hospital) attended the deceased from 12/9 , 19 83 , to 5/14 , 19 83 , that (I) (we) last saw the deceased alive on 12/9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE Margaret Mullins, M.D.		22c. DATE SIGNED May 18, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Margaret Mullins, M.D.				22e. ADDRESS 16 Murray Ave, Annapolis MD 21401		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	
23b. DATE May 18, 1983		23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Kings County NY		24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis, MD	
25a. DATE RECEIVED BY REGISTERAR MAY 17 1983				25b. REGISTERAR'S SIGNATURE [Signature]			



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New York City
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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 7 8 2

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles (NMI) Clark				2a. DATE OF DEATH MONTH DAY YEAR MAY 19 1983		2b. HOUR 7:50A M.	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 28, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Stevensville, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY Queen Anne		13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Holten Clark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Grimes		13e. STREET ADDRESS Stevensville, Md. 21666			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Wanda Steele Kentmore, Stevensville, Md. 21666			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5713 IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO, OR AS A CONSEQUENCE OF (b) ALCOHOLIC LIVER DISEASE (CIRRHOSIS) DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS SEVERAL YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a NONE							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov 18 19 81 to MAY 19 19 83 , that (I) (we) lost saw the deceased alive on MAY 18 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Charles W. Kinzer				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MAY 19, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. KINZER, M.D.				22e. ADDRESS ANNAPOLIS MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 21, 1983		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Stevensville Queen Anne Md	
24. FUNERAL DIRECTOR NAME ADDRESS Helffenbein Funeral Home Chester, Md.				25a. DATE REC'D. BY REGISTRAR MAY 23 1983		25b. REGISTRAR'S SIGNATURE J. Conish	

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

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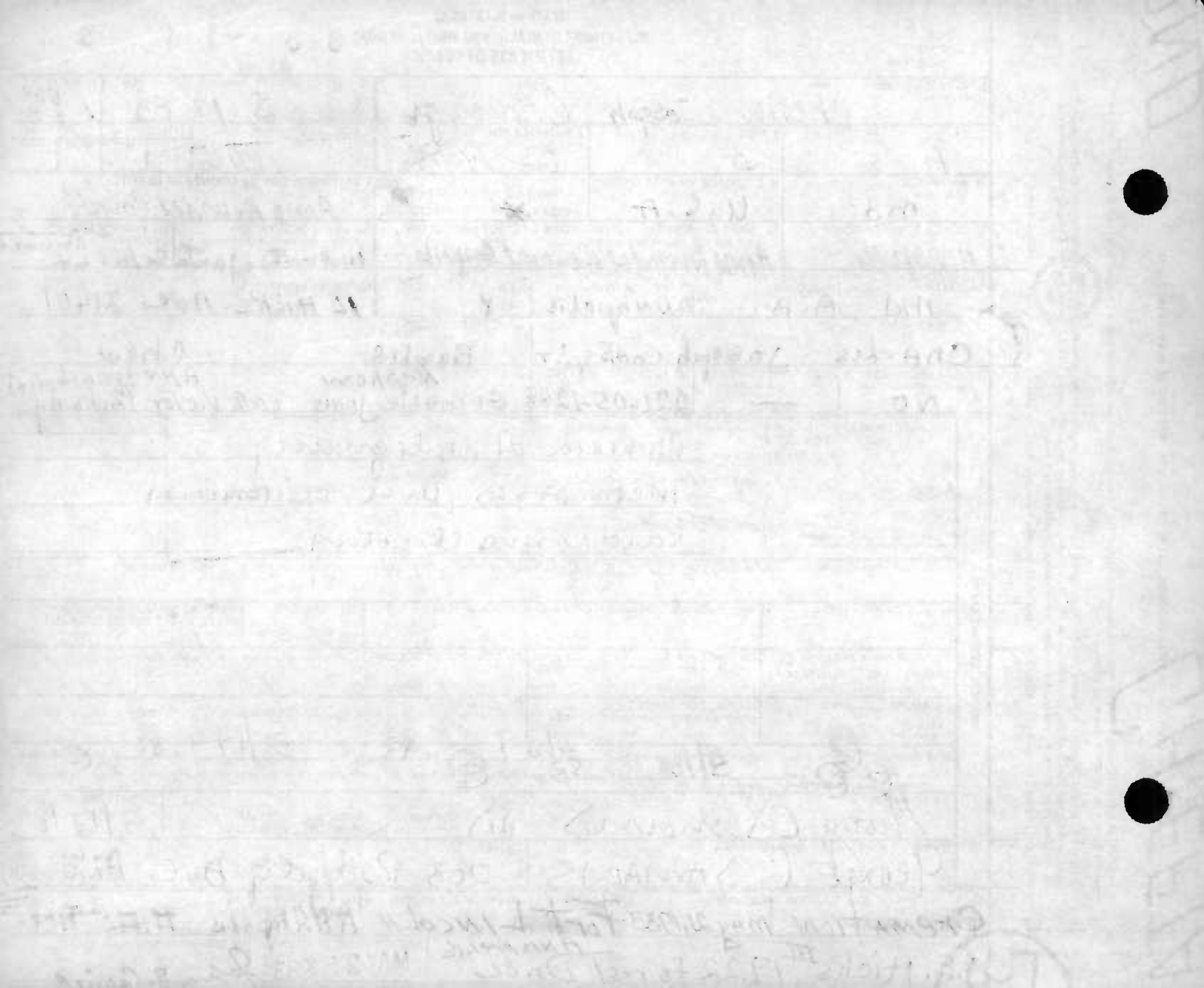
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			7. DATE OF DEATH		8. MONTH DAY YEAR	
1. DECEASED NAME (TYPE OR PRINT)			20. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Charles Joseph Coates, Jr.			5 17 83		8:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
M	B	02 14 74	69 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
md	U.S.A.		Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis	Anne Arundel General Hospital		Real estate janitor		School Lt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
md	md	A.A.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	10 HICKS AVE 21401		
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN)			
Charles Joseph Coates, Sr.	Berlie Chew		NO			
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
220-05-1248		Nephew		ANNAPOLIS, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia of malignancy. 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis, liver, pneumonia (c) Carcinoma @ colon		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 4/27/83 to 5/17/83, that (1) (two) last saw the deceased alive on 5/16/83 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.						
22b. SIGNATURE George C. Samaras		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/17/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
George C. Samaras		205 Ridgely Ave Annapolis, MD				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION		May 24, 1983		Fort Lincoln		ANNAPOLIS A.A. MD
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		
J.E. Hicks III		1922 Forest Drive		MAY 25 1983		

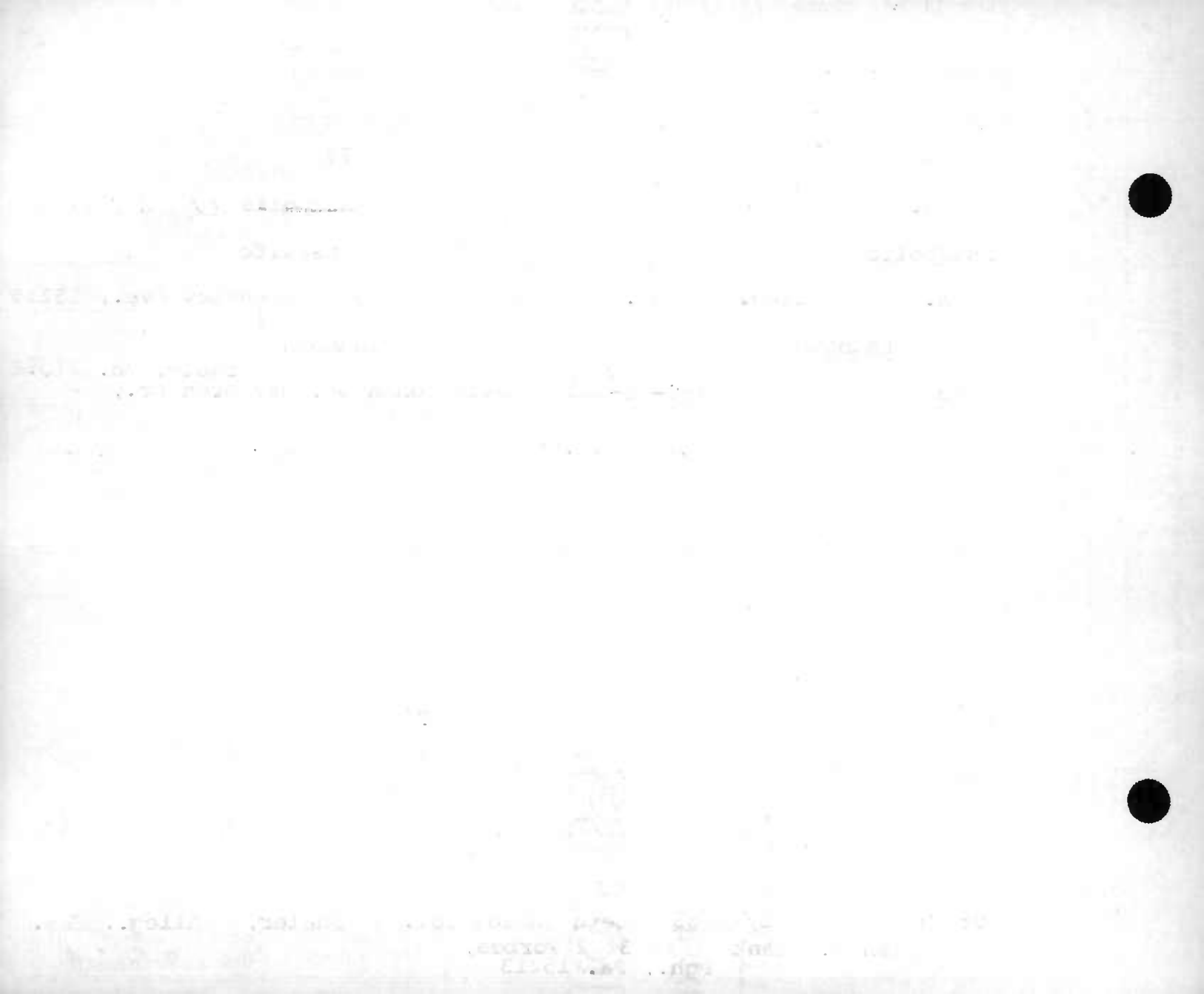


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 3 1 1 7 8 4 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			2b. HOUR		
Helen Cohen						5/14/83			4:17A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Fe		W		08 08 08		74 YRS.		MONTHS DAYS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Pa.			USA						Annapolis A.A. Co. MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel General Hospital			Housewife					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Pa.			Alleg.		Pgh.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1514 Beechview Ave., 15216		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Unknown			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			196-36-0631			David Cohen			Arnold, Md. 21012		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			Breast carcinoma metastatic to lungs.			2 yrs.		
1749			DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)								
			DUE TO, OR AS A CONSEQUENCE OF			(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from			4/16 19 83			to			5/14 19 83		
saw the deceased arise on			5/14 19 83			and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
									5/14/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE		
Burial			5/16/83		Beth Shalom Cem.		Shaler, Pa.		Alleg. Pa.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
NAME Alan M. Blank			ADDRESS 3222 Forbes, Pgh., Pa. 15213			MAY 31 1983			John J. Carver		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 1 1 7 8 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mabel Emmaline Corey			2a. DATE OF DEATH MONTH DAY YEAR MAY 12, 1983			2b. HOUR 7 ³⁰ A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 10, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY, MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Nurs. & Conv. Cen.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Own Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Sargable		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Emma UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT - daughter - ADDRESS 105 Altona Avenue Mrs. Carolyn Yockel/Pasadena, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) <u>Cardiac Failure.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diab. Mel. +</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>2 yrs.</u> <u>2 yrs.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Organic Brain Syndrome</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William H. Choate, MD.</u>		DEGREE		22c. DATE SIGNED 12 May 83.		22d. PHYSICIAN'S NAME (TYPE OR PRINT) William H. Choate MD	
22e. ADDRESS 2083 West St. Annapolis, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 14 May 83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A., MD.	
24. FUNERAL DIRECTOR NAME J. H. Singleton		ADDRESS Singleton Funeral Home/Glen Burnie MD.		25a. DATE REC'D. BY REGISTRAR MAY 16 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "UNITED STATES" and "MAY 1963" are faintly visible.]

[Handwritten text at the bottom left, possibly a signature or date.]

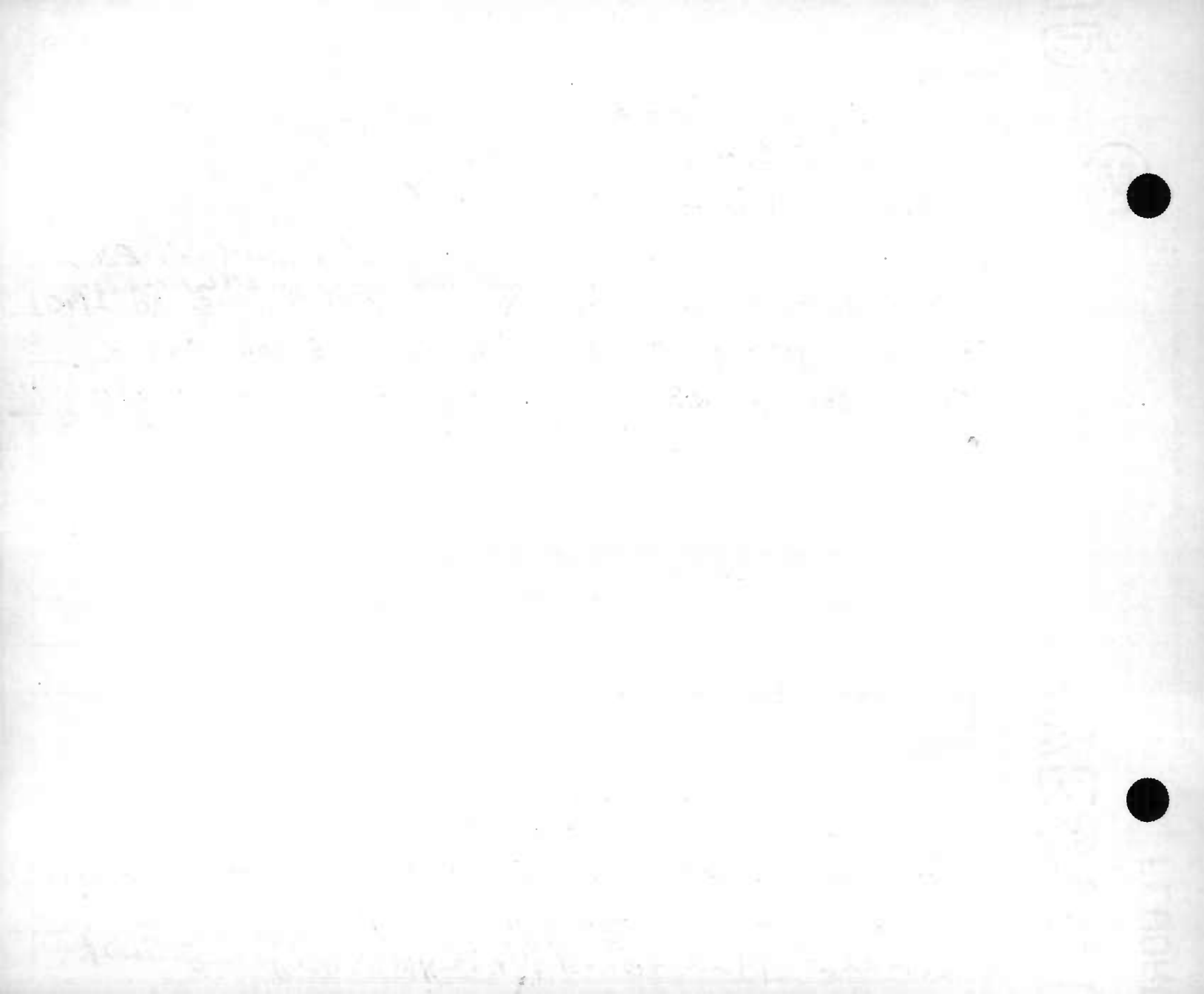
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 - 1 1 7 8 6 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) WILLIAM HOWARD CREEK				2a. DATE OF DEATH MONTH DAY YEAR 5-13-83				2b. HOUR 903 AM			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 7 1924		6. AGE (IN YEARS LAST BIRTHDAY) 58		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.							
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) ANNE ARUNDEL General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Box maker Freezer		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A.A. CO		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 705 Bestgate Rd 21401							
14. FATHER'S NAME FIRST MIDDLE LAST JAMES HENRY CREEK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ELLEN CREEK											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 218-143696		17. INFORMANT ADDRESS SARAH B. HAMILTON 1701 WELLS ST									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7800 Cardiac Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Daniel C. McCabe M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-13-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel C. McCabe MD		22e. ADDRESS 1521 Ritchie Hwy Ar Nold MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-17-1983		23c. NAME OF CEMETERY OR CREMATORY PINLAWN				23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. MD					
24. FUNERAL DIRECTOR NAME C. E. Hicks III		ADDRESS 1922 Forrest Drive		25a. DATE REC'D. BY REGISTRAR MAY 23 1983		25b. REGISTRAR'S SIGNATURE John J. Lander							

BP _____



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH83 11787
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Carl Spurgeon Davis			2a. DATE OF DEATH MONTH DAY YEAR 5/16/83			2b. HOUR 7:45 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) TN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto Body	
13a. STATE MD			13b. COUNTY A.A.		13c. CITY OR TOWN Davidsonville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Norman Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Docia Lacey			13e. STREET ADDRESS 315 Brick Church Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes 1944-1945			16b. SOCIAL SECURITY NO. 413-16-1986		17. INFORMANT Docia S. Davis		ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1991 Generalized Carcinomatosis from IMMEDIATE CAUSE (a) undetermined primary site Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/11 19 83 , to 5/16 19 83 , that (I) (we) lost saw the deceased alive on 5/16 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard N. Peeler M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/17/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard N. Peeler, M.D.			22e. ADDRESS 121 Cathedral St. Annapolis, MD						
23a. BURIAL, CREMATION, REMOVAL (ECIFY) Burial			23b. DATE May 19, 1983		23c. NAME OF CEMETERY OR CREMATORY Lakemont		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville, A.A. MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD			ADDRESS Annapolis, MD			25a. DATE REC'D. BY REGISTRAR MAY 18 1983			

BP



Carl Thompson
John White
Hans Arnold
H.A. General Hospital
H.A. District
Norman Davis
Yes, I am a member of the
Davis

James
H.A. General Hospital
H.A. District
Norman Davis
Yes, I am a member of the
Davis

James
H.A. General Hospital
H.A. District
Norman Davis
Yes, I am a member of the
Davis

James
H.A. General Hospital
H.A. District
Norman Davis
Yes, I am a member of the
Davis

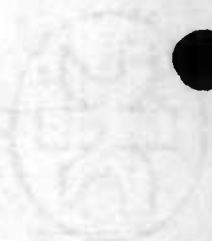
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1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 1 7 EDTS REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	
GILBERT		ELMORE	DAVIS	SR	
2. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
MAY		05	1983	0622 AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		July 21, 1926	
6. AGE (IN YEARS LAST BIRTHDAY)		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
56 YRS.				ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Warehouseman	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		21061	
Grocery		902 Sunnybrook Drive			
13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		A. A		Glen Burnie YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST William Howard Davis		FIRST MIDDLE LAST Julia Alice Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		WW-2		229-28-2546 Elizabeth Davis same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>< 1 hour</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Ulcerative Colitis (2) S/P Colectomy (3) Diabetes Mellitus</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>5/4</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		19 <i>81</i> to <i>5/5</i> 19 <i>83</i>		that (I) (we) last	
22b. SIGNATURE <i>Bernardino Alonso, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/5/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARDINO ALONSO M.D.		22e. ADDRESS 1406 CRAIN HIGHWAY SUITE 106 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/9/1983		Glen Haven Mrm. Pk Glen Burnie, A.A. Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Raymond C. Fink		Glen Burnie, Md.		MAY 5 1983	
				25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

BP



DATE	10/11/1935	TIME	10:15	PLACE	NEW YORK
NAME	JOHN J. HENRY	AGE	35	SEX	M
ADDRESS	1234 5th Ave, New York, N.Y.				
TELEPHONE	1-234-5678				
EMPLOYER	ABC Company, Inc.				
POSITION	Salesman				
EDUCATION	High School				
MARRIED	Yes				
CHILDREN	2				
RELIGION	Catholic				
POLITICAL	Democrat				
REMARKS	[Faint handwritten notes]				

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1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 1 7 8 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola Dallas Ditch		2a. DATE OF DEATH MONTH DAY YEAR 5 14 83		2b. HOUR 2P M	
3. SEX Female	4. RACE CAUCASIAN CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 1 25 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD	
10. CITY OR TOWN OF DEATH BROOKLYN PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN N.C., H.C.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY BALTO. CITY	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 600 LIGHT STREET APT #923 21225	
14. FATHER'S NAME FIRST MIDDLE LAST COLLIPLOWER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 212-01-1793		17. INFORMANT E. EARLE HENDERSON		ADDRESS 1122 W. GYPSY LN. TOWSON MD 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4292 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ① BATTEN'S DISEASE ② PERIPHERAL VASCULAR INSUFFICIENCY ③ C.V.A.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/13/81 to 5/14/83, that (II) (we) lost the deceased alive on 5/14/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE K.D. HARMASANA		DEGREE MD.		22c. DATE SIGNED 5/14/1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.D. HARMASANA		22e. ADDRESS #8, 16th AVE. BALT. Md 21225		22f. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-18-83		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE ELICOTT City Howard MD		24. FUNERAL DIRECTOR NAME Slack Funeral Home			
24b. ADDRESS Rd. Box 268 ELICOTT City MD		25a. DATE REC'D. BY REGISTRAR MAY 31 1983			
25b. REGISTRAR'S SIGNATURE John J. Lamer					

BP

1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						20. DATE KNOWN OF DEATH ESTI- MATED						MONTH DAY YEAR						2b. HOUR					
Lelia Atkins Dodson												May 12 1983						4:15 PM											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD						19											
Female		Caucasian		Mar. 21, 1901		82																							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH											
Virginia						USA												Anne Arundel MD											
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY											
Pasadena						7861 Outing Avenue, Pasadena						Housewife						Own Home											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS													
Md.						AA		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7861 Outing Avenue, 21122																	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																							
Lloyd Atkins						Martha Atkins																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS																	
No												Peggy Dodson, same as 13																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>2389</u> IMMEDIATE CAUSE (a) <u>Carcinoid</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE <u>Richard E. Cook</u>						TITLE (SPECIFY) M.D. <u>Dep. Sub.</u> MEDICAL EXAMINER												DATE SIGNED <u>5/12/83</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>RICHARD E. COOK</u>						ADDRESS <u>113 Cathedral St. Annap., Md. 21401</u>																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial						15 May 83						Sperryville Cemetery						Sperryville, Virginia											
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE																	
James S. Kirkley, Glen Burnie, Maryland						MAY 18 1983						<u>John J. Connel</u>																	



Feb. 3 1912
Feb. 2 1912

1952

10/10/12
10/10/12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY, THE MEDICAL EXAMINER, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR					
JOHN FRANCIS DUKE, III								XX5-15-83		19						M					
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
M	W	11/9/59		23 YRS.						5-26-83		19						2:25P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County															
MD		USA				MD															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN BALTIMORE CITY - GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Sandy Point		Bay Bridge										None		None							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		205 Upnor Rd. 21212													
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME															
John F. Duke, Jr.						Mary Iglehart Taylor															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
No						Mr. John F. Duke, Jr., Same															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9540 IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5-14-83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found in the bay													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, FACILITY, FACTORY, FARM, ETC.) Bay				21f. LOCATION STREET CITY OR TOWN STATE Bay Bridge Sandy Point, MD													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 5-27-83							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
Margarita A. Korell, M.D.				111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Cremation				5/28/83		Green Mount				Balto., MD											
24. FUNERAL DIRECTOR NAME														25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212														MAY 31 1983				John J. Canich			

NEEDS FOR THE
W. H. ... Co.

Green Mount

...

...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

BP

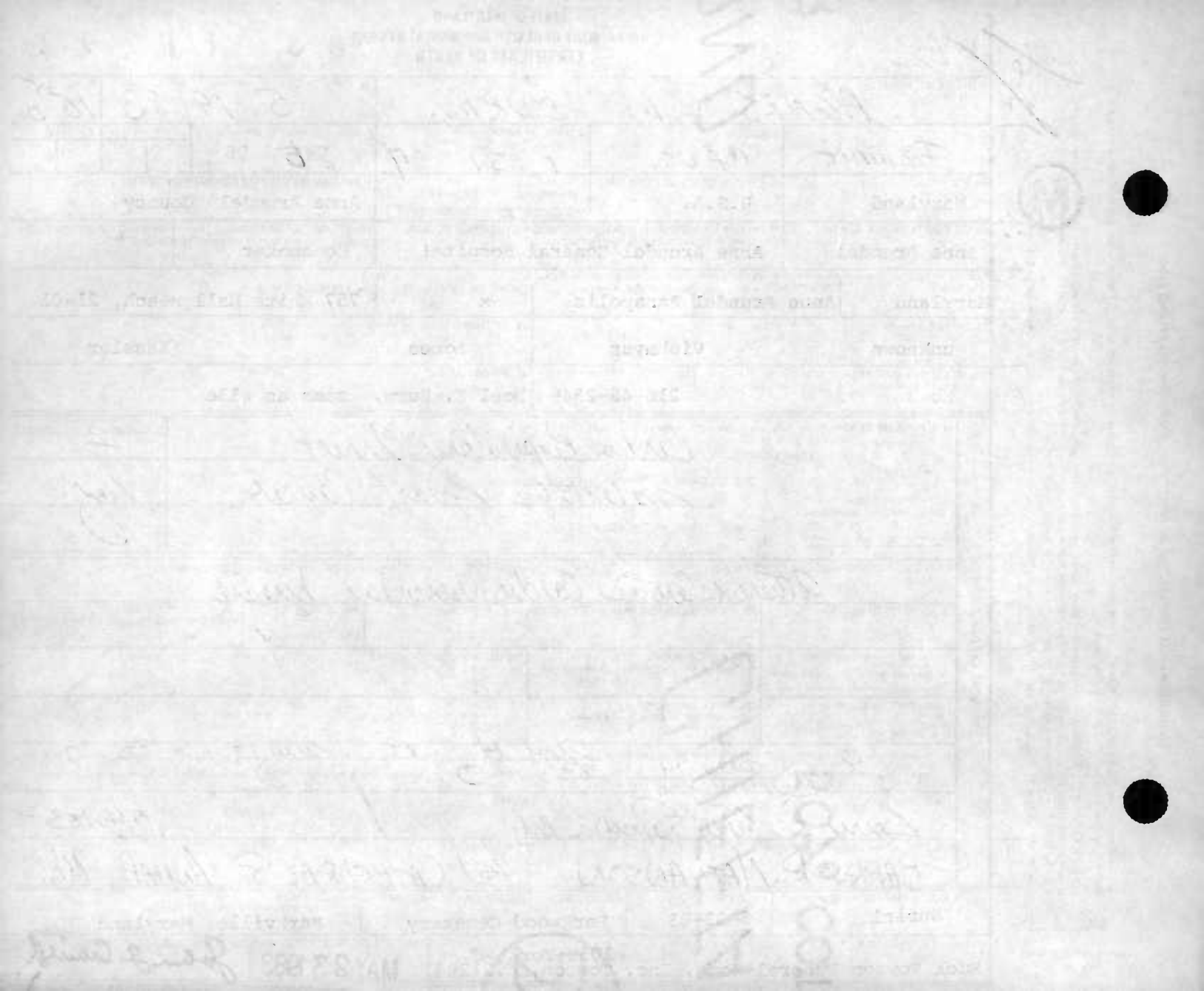
DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 7 9 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AGNES M DURM.			2a. DATE OF DEATH MONTH DAY YEAR 5 19 83		2b. HOUR MIN 10¹⁵ PM
3. SEX FEMALE	4. RACE CAUS.	5. DATE OF BIRTH MONTH DAY YEAR 1 31 97		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 14 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Anne Arundel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Annapolis 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 757 White Hall Beach, 21401					
14. FATHER'S NAME FIRST MIDDLE LAST unknown Viehmyer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Kessler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-46-2349		17. INFORMANT ADDRESS Noel E. Durm, same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Atherosclerotic Cardio-Vascular Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOBSEY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 14 , 19 83 , to May 19 , 19 83 , that (I) (we) lost saw the deceased alive on May 19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Barry R. Nathan		DEGREE M.D.		22c. DATE SIGNED 5/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON		22e. ADDRESS 121 CATHEDRAL ST. ANNAP. MD.			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 5-23-83		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204			
25a. DATE REC'D. BY REGISTRAR MAY 23 1983		25b. REGISTRAR'S SIGNATURE John J. Carish			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	1 1 7 9 3				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alicia Amber Edenger										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5/25/83		2b. HOUR M A M 11:37			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 16, 1983		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 2 9		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 2 9		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5/25/83		7d. HOUR M A M 11:37			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County		MD.	
10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7254 E. Furnace Branch Road				21061	
14. FATHER'S NAME FIRST MIDDLE LAST Gary Edinger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wendy Didlake				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO.			
17. INFORMANT Gary Edinger, same as 13				ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden infant death Syndrome</u> 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 5/25/83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 27 May 83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA Md.					
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 31 1983				25b. REGISTRAR'S SIGNATURE <i>John G. Carver</i>							

STATION
NOTES

Handwritten notes and signatures, including a large signature that appears to read "The... of...".



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))

20AM 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11794
1. FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH				2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) Robert Norman Ewing, Jr.						2b. DATE KNOWN OF DEATH ESTIMATED 5-14-1983				2b. HOUR 3:30 a.m.
3. SEX male	4. RACE white	5. DATE OF BIRTH 2/23/1965	6. AGE (IN YEARS) 18 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD 5-14-1983				2d. HOUR 3:30 a.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) plumbing		12b. KIND OF BUSINESS OR INDUSTRY Johnny Be Quic		
13a. STATE Md.						13b. COUNTY A.A. Co.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3536 Oak Dr. Cape Loch Haven 21037	
14. FATHER'S NAME FIRST Robert MIDDLE N. LAST Ewing Sr.			15. MOTHER'S MAIDEN NAME FIRST Rena MIDDLE A. LAST Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		(IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 431-27-4369		17. INFORMANT ADDRESS Rena A. Ewing 3536 Oak Dr. Edgewater, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8159 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR-A.M. MONTH DAY YEAR 3:00PM 5-14-1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject in auto/fixed object impact				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION Loch Haven Rd. & Pocohontas Drive, Edgewater, Anne Arundel Co. Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Dennis F. Smyth MD			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 5-15-83	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn Street, Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/17/83		23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery			23d. LOCATION Davidsonville A.A. Md. STATE		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home			ADDRESS 12 Ridgely Ave. Ann. Md.			25a. DATE REC'D. BY REGISTRAR MAY 18 1983			25b. REGISTRAR'S SIGNATURE	



UNCLASSIFIED

SECRET



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100-44-4444

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

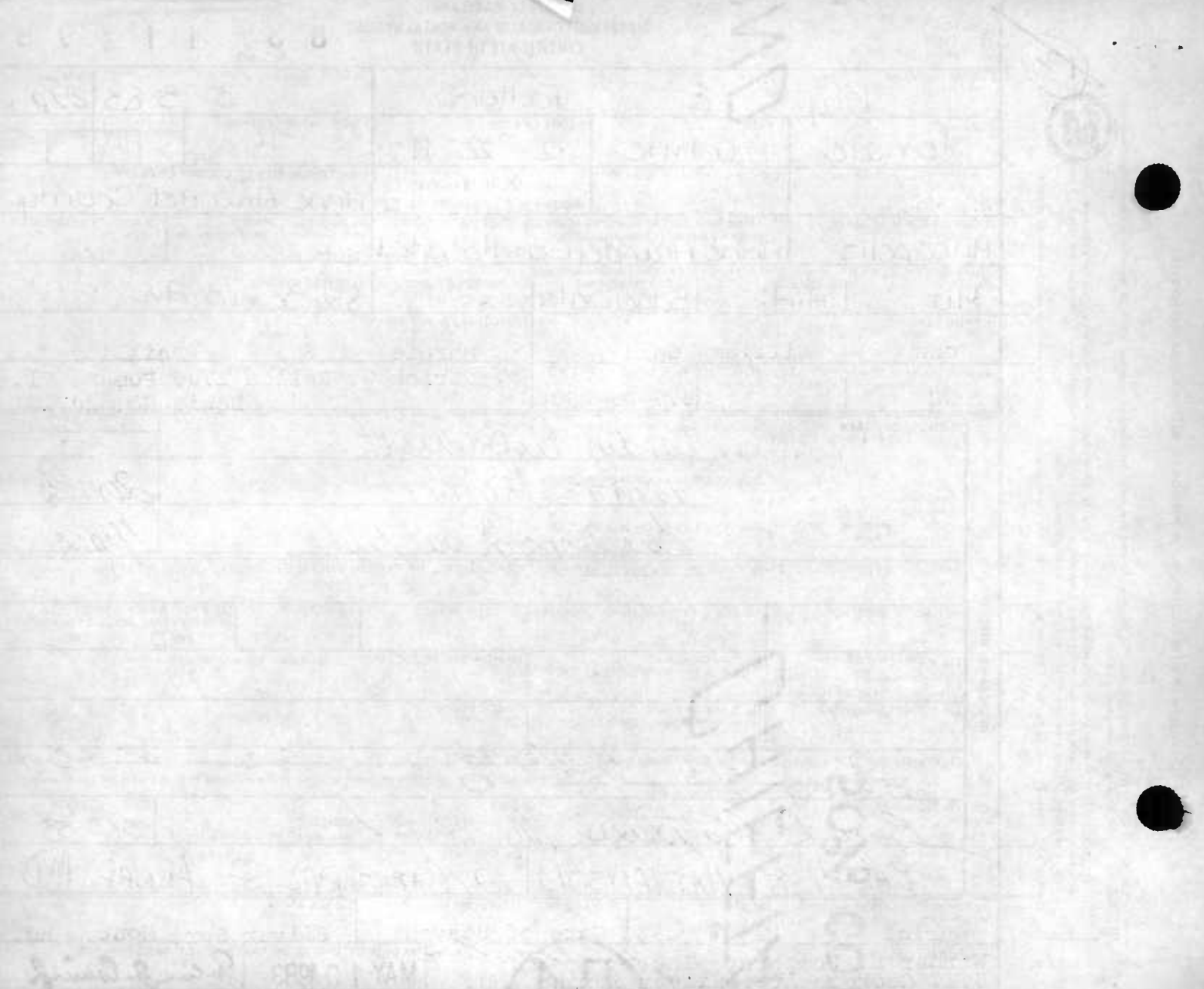
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 11795 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Lily E Fallon				2a. DATE OF DEATH MONTH DAY YEAR 5 3 83			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 20 11		6. AGE (IN YEARS LAST BIRTHDAY) 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY A.A. 13c. CITY OR TOWN Edgewater				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST John William Cain				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margie Phillips			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-09-0936		17. INFORMANT ADDRESS Frederick W. Fallon 1700 Pomana Pl. Bowie Md. 20716			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Resp Arrest 5715 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septic Failure DUE TO, OR AS A CONSEQUENCE OF (c) Enlarged & Ruptured Liver APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/27/83 , 19 83 , to 5/3 , 19 83 , that (I) (we) last saw the deceased alive on 5/3 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE Barry R. Nathanson MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON				22e. ADDRESS 121 CATHARAL ST. ANNAP MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 7, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spr. Mont. Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Ave. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR MAY 10 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Naomi Celeste Fay					2a. DATE OF DEATH MONTH DAY YEAR May 9, 1983		2b. HOUR P. 6:15 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 15, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reg. Nurse		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. STATE Maryland					13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward T. Kirkley, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Reese					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-7342		17. INFORMANT ADDRESS Celeste Stinchcomb, Same as 13						
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3310 IMMEDIATE CAUSE (a) <u>Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 82, to 19 83, that (I) (we) last saw the deceased alive on 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Lowe				22c. DATE SIGNED 12/9/83				22d. ADDRESS 77 West Street, Annapolis, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 13 May 1983		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		23e. DATE REC'D. BY REGISTRAR MAY 16 1983		
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				24. REGISTRAR'S SIGNATURE John J. Conner						



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 7 9 7 REG. NO.
1. DECEASED NAME (TYPE OR PRINT) EDITH K. FEIGE		2a. DATE OF DEATH MONTH DAY YEAR 5-7-83		2b. HOUR 6⁰⁵ M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 6-29-1900	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD	
10. CITY OR TOWN OF DEATH CROWNSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRFIELD NURSING CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD.		13c. CITY OR TOWN ARNOLD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILMER SAGLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY GARDINER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 159-07-8157	17. INFORMANT ADDRESS M. William G. Feige - 1047 Landon Lane 21012	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Recent Strokes - Aphasia				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (1) (this hospital) attended the deceased from 4/29/83 to 5/7/83 , that (1) (we) lost the deceased 4/29/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.				
22a. SIGNATURE Arnold G. Alexander, M.D.		DEGREE M.D.	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD G. ALEXANDER, M.D.		22e. ADDRESS 650 RITCHIE HWY. - SEVERNA PARK, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5-10-83	23c. NAME OF CEMETERY OR CREMATORY HILLSIDE CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE ROSLYN - MONTGOMERY Co. - PA.	
24. FUNERAL DIRECTOR NAME ADDRESS Parten Miller - 7527 Harford Rd.		25. DATE REC'D. BY REGISTRAR MAY 16 1983		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 327-1234.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR		8 3 1 1 7 9 8				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sadie Fillah					2a. DATE OF DEATH MONTH DAY YEAR 5- 12 83			2b. HOUR 2:45P.M.	
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 21 88		6. AGE (IN YEARS LAST BIRTHDAY) 94		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lebanon		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel, Co. MD.			
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knollwood Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2306 Wintergreen Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 264-92-0560		17. INFORMANT ADDRESS Charles Fillah, Son Same as Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Severe Cardio-Vascular Dy DUE TO, OR AS A CONSEQUENCE OF (c) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Gangrene Left Foot.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from OCT 13 , 19 81 , to MAY 10 , 19 85 , that (1) (we) last saw the deceased alive on MAY 4 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Barry E. Nathanson MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY E. NATHANSON				22e. ADDRESS 121 CATHEDRAL ST ANNAP MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-16-83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Md.			
24. FUNERAL DIRECTOR NAME Robt E Wilhelm		ADDRESS 4308 Suitland Rd., Suitland, Md.		25. DAY, MONTH, YEAR OF REGISTRATION MAY 17 1983					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

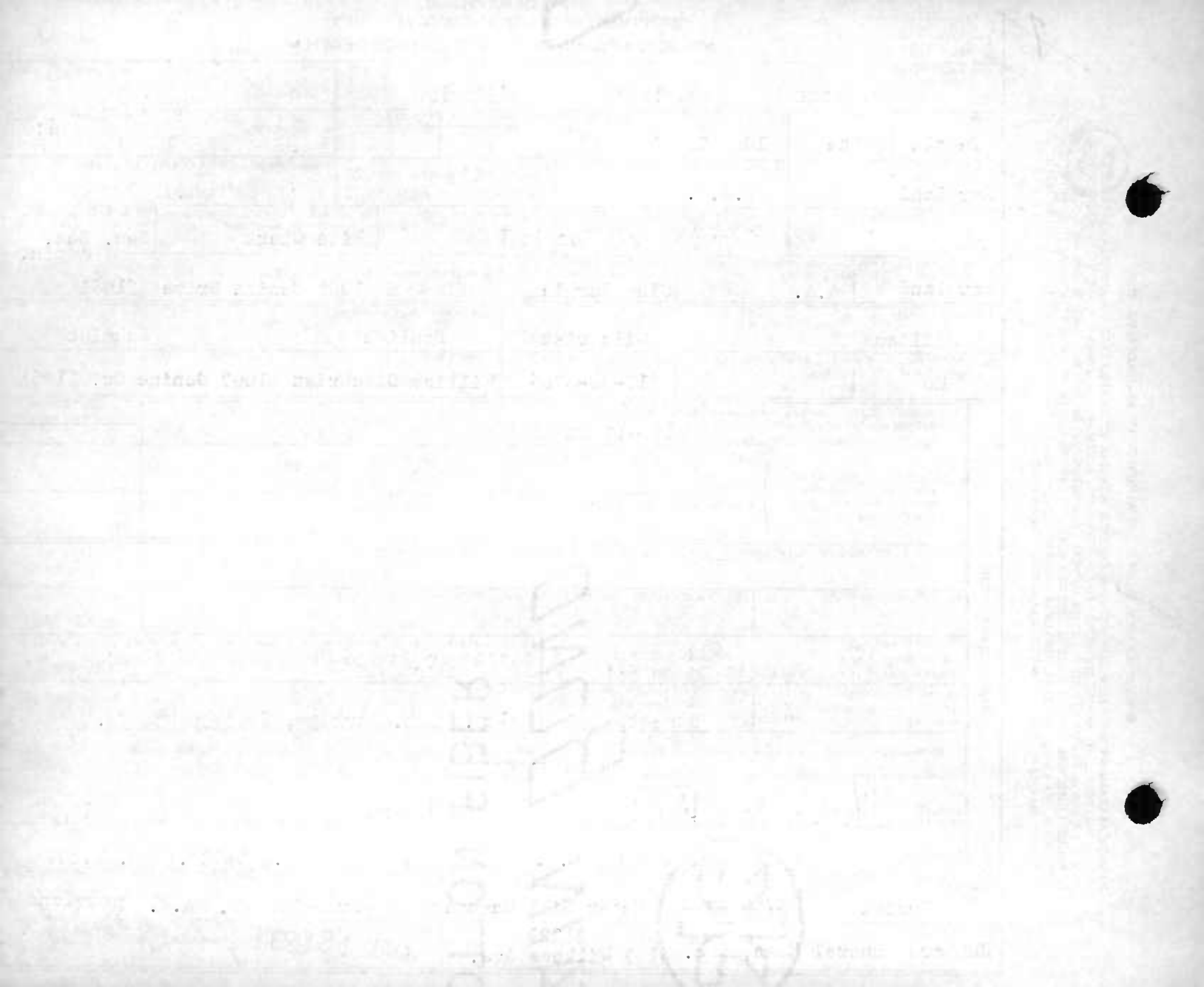
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8311799 DST			
1. FOR STATE REGISTRAR							
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYER NW FRIEDMAN				2a. DATE OF DEATH MONTH DAY YEAR MAY 14, 1983			
3. SEX Male				2b. HOUR 9:20 am			
4. RACE White				5. DATE OF BIRTH MONTH DAY YEAR January 21, 1898			
6. AGE (IN YEARS (LAST BIRTHDAY)) 85 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Theatre Operator				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Anne Arundel 13d. CITY OR TOWN Pasadena				13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13f. STREET ADDRESS 738 Beach Drive 21122							
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Friedman				15. MOTHER'S MAIDEN NAME Julia Wasserman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216-03-7022			
17. INFORMANT Mrs. Mary E. Anthony				Address Cherry Hill, N.J. 08002 108 Rhode Island Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Heart Failure Rhythm Abnormal Heart disease (c) DUE TO, OR AS A CONSEQUENCE OF (d) DUE TO, OR AS A CONSEQUENCE OF (e) DUE TO, OR AS A CONSEQUENCE OF				ABSTRACT/INTERVIEW BETWEEN DEATH AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Atrial Failure							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ON <input type="checkbox"/>				21e. PLACE OF INJURY HOME, STREET, FACTORY, OFFICE, FARM, ETC.			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased on 5/13/83, to 4/11/83, and that (I) (we) lost the deceased on or about 5/14/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE J. B. Ramirez M.D.				22c. DATE SIGNED 5/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE B. RAMIREZ, M.D.				22e. ADDRESS 7845 OAKWOOD ROAD # 205 GLEN BURNIE, MD. 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment				23b. DATE May 17, 1983			
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel Md.			
24. FUNERAL DIRECTOR McCully Funeral Home of Pasadena Mountain and Lock Neck Roads Pasadena, Md.				25a. DATE REC'D. BY REGISTRAR MAY 17 1983			
25b. REGISTRAR'S SIGNATURE John J. Connelley							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11800	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			2b. HOUR		
Donna Marie Gilchrist						5/15/83 19			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
female	White	10 25 61	21 YRS.			5/15/83 19			1:00 A M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Anne Arundel County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Fort Meade		Kimbrough Army Hospital				File Clerk		Soc. Sec. Admin.			
13. STATE											
Maryland											
13b. COUNTY											
A.A.											
13c. CITY OR TOWN											
Glen Burnie											
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
13e. STREET ADDRESS											
1002 Genine Drive 21061											
14. FATHER'S NAME											
William Gilchrist											
15. MOTHER'S MAIDEN NAME											
Pauline Schmidt											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)											
NO											
16b. SOCIAL SECURITY NO.											
217-80-8706											
17. INFORMANT											
William Gilchrist											
ADDRESS											
1002 Genine Dr. 21061											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Multiple Injuries											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
21b. TIME OF INJURY											
11:04 pm 5/14/83											
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
passenger jumped from auto and struck by another auto											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)											
street											
21f. LOCATION											
Balto./Wash. Parkway, Southbound, Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE											
Margarita A. Korell, M.D.											
TITLE (SPECIFY)											
Assistant											
DATE SIGNED											
5/16/83											
EXAMINER'S NAME (TYPE OR PRINT)											
Margarita A. Korell, M.D.											
ADDRESS											
111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)											
Burial											
23b. DATE											
5/19/83											
23c. NAME OF CEMETERY OR CREMATORY											
Cedar Hill Cemetery											
23d. LOCATION											
Brooklyn Pk. A.A. Maryland											
24. FUNERAL DIRECTOR											
Hubbard Funeral Home, Inc.											
ADDRESS											
21229 4107 Wilkens Ave.											
25a. DATE REC'D. BY REGISTRAR											
MAY 18 1983											
25b. REGISTRAR'S SIGNATURE											
John D. Smith											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with you until after death is pronounced by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BE

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 8 0 1	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
Donald Curtiss Gilley				5 11 83	
3. SEX				2b. HOUR	
MALE				9 58 A M	
4. RACE				6. AGE (IN YEARS LAST BIRTHDAY)	
WHITE				78 YRS.	
5. DATE OF BIRTH				IF UNDER 1 YEAR	
6 4 - 04				MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				9. BALTIMORE CITY OR COUNTY OF DEATH	
WISCONSIN				ANNE ARUNDEL COUNTY MD.	
7b. CITIZEN OF WHAT COUNTRY?				12b. KIND OF BUSINESS OR INDUSTRY	
USA				MUSIC	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
ANNE ARUNDEL GEN. HOSPITAL				PROFESSOR RET	
13a. STATE				13b. STREET ADDRESS	
MD.				1917 HARWOOD ROAD	
13c. CITY OR TOWN				21401	
Annapolis					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST				FIRST MIDDLE LAST	
ALBERT Gilley				MIRIAM GRAVES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)				17. INFORMANT	
YES				DOORILLY Y. GILLEY #13	
16b. SOCIAL SECURITY NO.				ADDRESS	
1942 - 44 316-05 2599					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST					
4860					
DUE TO, OR AS A CONSEQUENCE OF					
(b) MYOCARDIAL INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF					
(c) PNEUMONIA					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
None					
19a. DATE OF OPERATION				20a. AUTOPSY?	
				YES NO	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES NO	
21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
HOUR A.M. MONTH DAY YEAR					
P.M. 19					
21d. INJURY OCCURRED				21e. LOCATION	
WHILE AT WORK NOT WHILE AT WORK				STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
22a. I certify that (1) this hospital attended the deceased from 5/11 1983 to 5/11 1983, and that in my opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE				22c. DATE SIGNED	
Wm. A. Dabbs				5/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
DABBS, W. A.				703 GIDDINGS AVE, ANNAPOLIS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE	
Burial				5/13/83	
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Hillcrest				Annapolis AA MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR	
Taylor Funeral Chapel				MAY 16 1983	
25b. REGISTRAR'S SIGNATURE					
John J. Conner					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 will be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 8 0 2 REG. NO.	D.S.T.
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD GOLDWEIS			2a. DATE OF DEATH MONTH DAY YEAR MAY 8, 1983		2b. HOUR A. 10:50
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MAY 27 1914	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY, MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHIPFITTER		12b. KIND OF BUSINESS OR INDUSTRY STEEL FACTORY.	
13a. STATE MARYLAND	13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN SEVERNA PARK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 675 ELLERSLIE RD. 21146	
14. FATHER'S NAME FIRST MIDDLE LAST KARLES — GOLDWEIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGOTA — BERKOWKIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-01-3127		17. INFORMANT ADDRESS BETTY GOLDWEIS (SAME AS 13)	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST 1991 DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/5 , 19 83 , to 5/8 , 19 83 , that (I) (we) last saw the deceased alive on 5/8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Glenn F. Robbins		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN F. ROBBINS, M.D.		22e. ADDRESS 1404 Crain Highway, S., #300 Glen Burnie, Maryland, 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 12, 1983		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE ANNE ARUNDEL MD.					
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO		501 RITCHIE HWY. SEVERNA PARK, MD.		25a. DATE REC'D. BY REGISTRAR MAY 12 1983	
		25b. REGISTRAR'S SIGNATURE John J. Canine			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 1 8 0 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
Ira L. Gorrell				May 10 1983		P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		Oct. 26, 1890		92 YRS.	
7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
WV		USA				Anne Arundel MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Annapolis Convalescent Ctr.		Retired Guard		US Gov't	
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
MD		A.A.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1605 Burnside St. 21403	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
John B. Gorrell				Emiline Gattrell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes				215 32 7592		Rachel B. Gorrell. Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5990 DUE TO, OR AS A CONSEQUENCE OF (b) urinary tract infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) and (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
H.D. Goldstein				M.D.		5/10/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Howard D. Goldstein MD				205 Ridgely Ave, Annapolis MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		May 13, 1983		Hillcrest		Annapolis A.A. MD	
24. FUNERAL DIRECTOR NAME				24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Taylor Funeral Chapel-Annapolis, MD						MAY 16 1983	
				25b. REGISTRAR'S SIGNATURE			
				Joan J. Canine			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 0 4
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EVELYN A GRANT		2a. DATE OF DEATH MONTH DAY YEAR MAY 26, 1983		2b. HOUR 325 AM
SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 19 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A NURSING FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Veterinary Aid	12b. KIND OF BUSINESS OR INDUSTRY Private
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Odenton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Murray		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Louis J. Grant Same as #13c

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4249 IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>valvular heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>83</u> , to <u>5-26</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>5-26</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Paul S. Rhodes</u>		DEGREE		22c. DATE SIGNED <u>5-27-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL S. RHODES, M.D.		22e. ADDRESS 1667 CROFTON CENTER CROFTON, MARYLAND 21114			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 27 Ma 7 83	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crem.	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md
24. FUNERAL DIRECTOR NAME FLECK FUNERAL HOME, INC.		25a. DATE REC'D. BY REGISTRAR MAY 27 1983	
26. ADDRESS 7601 Sandy Spring Rd. Laurel Md. 20707		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO THE DIRECTOR, U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

FROM THE SECRETARY, U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

SUBJECT: [Illegible]

[Illegible text follows]

Very truly yours,
[Illegible Signature]

Enclosed for the Bureau are [Illegible]

Very truly yours,
[Illegible Signature]

Enclosed for the Bureau are [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 8 0 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HARRY NIMM Green				2a. DATE OF DEATH MONTH MAY DAY 4 YEAR 1983				2b. HOUR 3:30 P M			
3. SEX male		4. RACE B		5. DATE OF BIRTH MONTH June DAY 27 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		7. IF UNDER 74 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD.					
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVYLAND			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md				13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 104 CLAY ST 21401	
14. FATHER'S NAME FIRST HARRY MIDDLE LAST Green, Sr				15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE LAST MARIA				16. ADDRESS ANNAPOLIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. W.W.I.		17. INFORMANT Mrs. Lillie Mae Green				17. ADDRESS 104 CLAY ST	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CHRONIC MYOPATHY (c) ARTERIO SCLEROSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC OBSTRUCTIVE LUNG DISEASE											
9a. DATE OF OPERATION 5/4/83		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED SINUS POLYPS INFECTIONS				9c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 1616 FOREST DRIVE ANNAPOLIS 21403		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from 5/4 19 83 to May 4 19 83 , that (I) (we) last saw the deceased alive on 5/4 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald C. Roane, M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald C. Roane, M.D.				22e. ADDRESS 1616 FOREST DRIVE ANNAPOLIS 21403							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-10-1983		23c. NAME OF CEMETERY OR CREMATORY VETERANS				23d. LOCATION CITY OR TOWN Crownsville COUNTY A.A. STATE md			
24. FUNERAL DIRECTOR NAME C.E. Hicks III ADDRESS 1922 Forest Drive ANNAPOLIS, MD				25a. DATE REC'D. BY REGISTRAR MAY 9 1983		25b. REGISTRAR'S SIGNATURE John J. Lander					

U.S. 500 - 1000 10000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

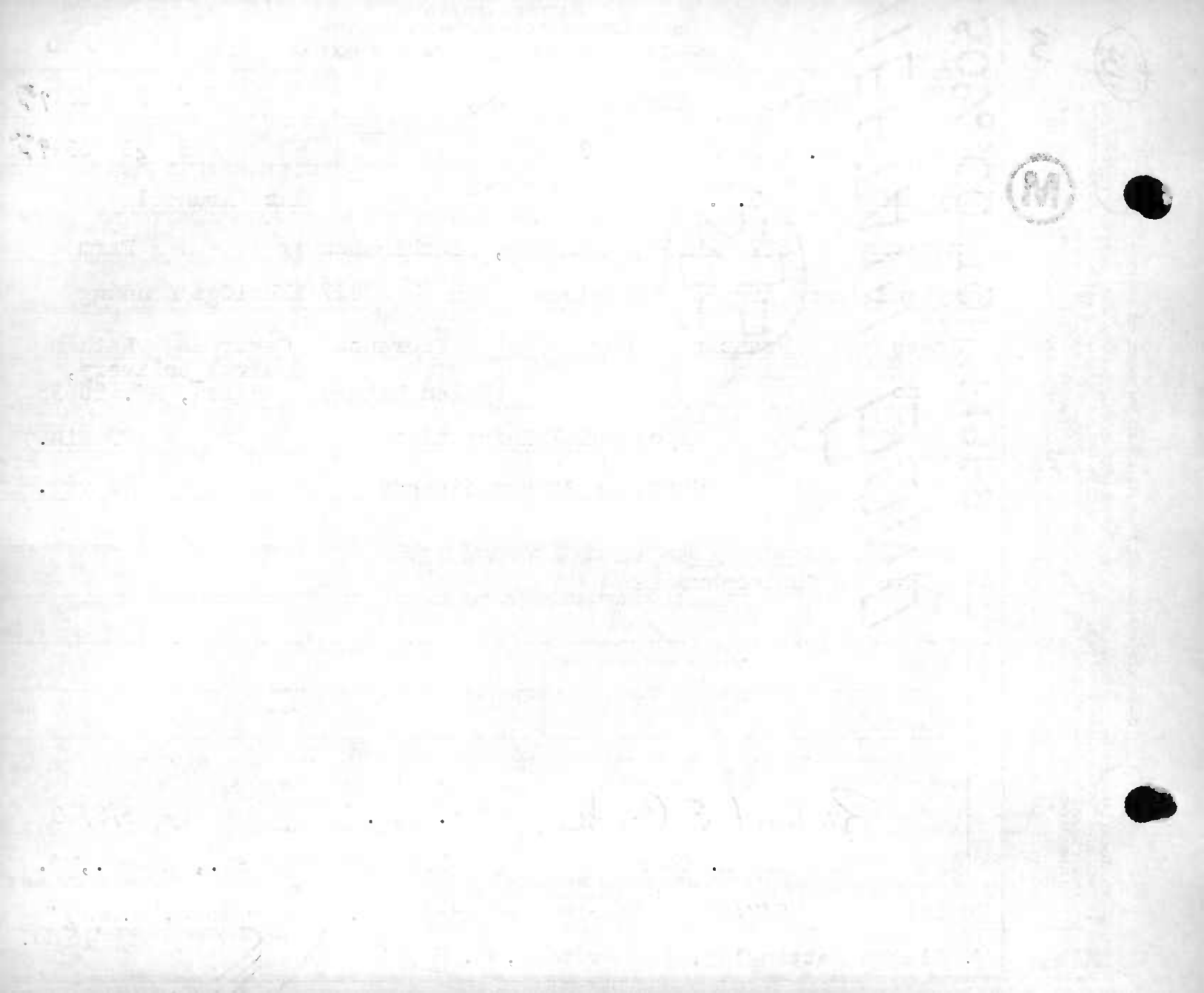
BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11806

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE ESTI- MATED		2c. DATE PRONOUNCED DEAD		2d. HOUR 19 83		2e. HOUR 19 83			
1. DECEASED NAME (TYPE OR PRINT)		Charles		Adrian		Guy							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.								
Male	Cauc.	3 30 20	63 YRS.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland	U.S.				Anne Arundel								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Linthicum	827 Elkridge Landing, Linthicum		Farmer		Farm								
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS									
Maryland		Anne Arundel		Linthicum		827 Elkridge Landing							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
James		Francis		Guy		Florence		Gertrude		Latham			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT									
no				Helen Latham		General Delivery, Helen, Md. 20635							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		5 min.					
4100		DUE TO, OR AS A CONSEQUENCE OF		Coronary Artery disease		6 yrs.							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF									
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		Chronic Schizophrenia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE		Richard E. Cook		TITLE (SPECIFY) Sub. Dep.		MEDICAL EXAMINER		DATE SIGNED		5/3/83			
EXAMINER'S NAME (TYPE OR PRINT)		Richard E. Cook		ADDRESS		113 Cathedral St., Annap., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		5/7/83		Charles Memorial Gdn.		Leonardtown, St. Mary's							
24. FUNERAL DIRECTOR NAME		W. Clarke Mattingley		ADDRESS		Leonardtown, Md.		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		Md.	
								MAY 9 1983					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 1 1 8 0 7
REG. NO. EDT1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE HAAS			2a. DATE OF DEATH MONTH DAY YEAR MAY 22, 1983		2b. HOUR 620 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1904		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress- Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY AA	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Curry Gibson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 306-07-5359		17. INFORMANT ADDRESS Lucy Day, Same as 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1890

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) METASTASIS CARCINOMA KIDNEY

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION 7/9/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA Rt KIDNEY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 5/20/83, 1983, to 5/23, 1983, that (1) (we) last saw the deceased alive on 5/20/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Victor Salama		DEGREE		22c. DATE SIGNED 5/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VICTOR SALAMA, M.D.		22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 25 May 83	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD		25a. DATE REC'D BY REGISTRAR MAY 25 1983	25b. REGISTRAR'S SIGNATURE John J. Carver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Form with multiple sections and fields, including a header area with a date field (1944) and a title field (OFFICE OF THE SECRETARY OF THE ARMY). The form contains various checkboxes and text boxes, some of which are filled with handwritten or stamped information. A large, stylized 'A' is visible in the center of the form.

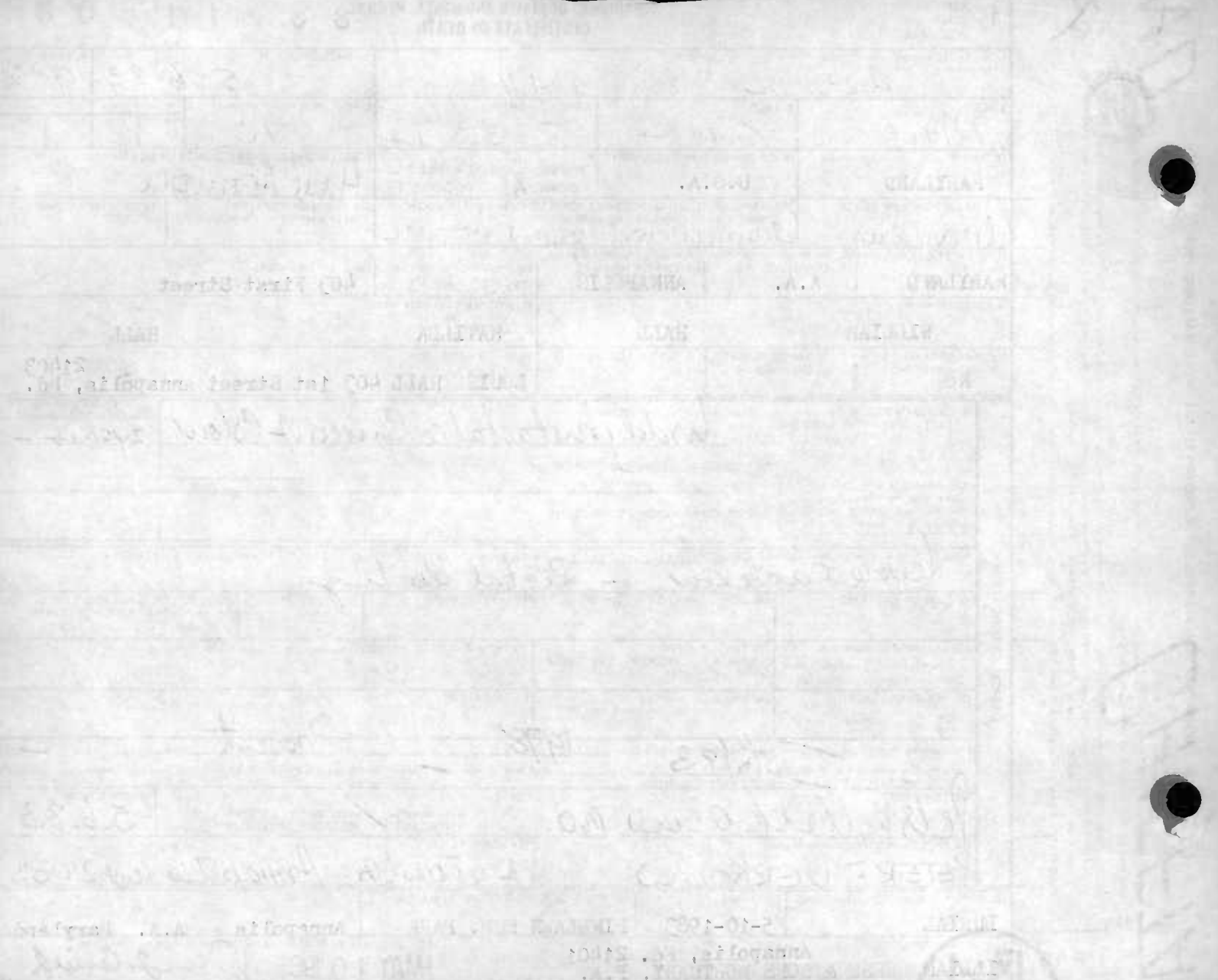


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is required for the body to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83-11808	
1. DECEASED NAME (TYPE OR PRINT) Arthur E. Hall						2a. DATE OF DEATH MONTH 5 DAY 6 YEAR 83			2b. HOUR 9:38A		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 8 DAY 30 YEAR 12		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Lumpkin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 403 First Street		21403	
14. FATHER'S NAME FIRST WILLIAM MIDDLE LAST HALL				15. MOTHER'S MAIDEN NAME FIRST MATILDA MIDDLE LAST HALL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 21403 LOUISE HALL 403 1st Street Annapolis, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Insidely metastatic Cancer of Colon 1539 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.1a Severe Cachexia - Rectal bleeding											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 1978		CITY OR TOWN Present		COUNTY 	
22. I certify that (I) (this hospital) admitted the deceased from 5/6/83 , 19 78 , to Present , 19 , that (I) lost saw the deceased alive on 5/6/83 , 19 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I was told) did not view the body after death.											
23. SIGNATURE Peter F. Verkouw M.D.						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-6-83	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUW						23b. ADDRESS 1419 Forest Dr. Annapolis Md 21403					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5-10-1983		23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK		23d. LOCATION CITY OR TOWN Annapolis COUNTY A.A. STATE Maryland			
24. FUNERAL DIRECTOR NAME William Reese & Sons Mortuary, P.A. ADDRESS Annapolis, Md. 21401						25. DATE REC'D. BY REGISTRAR MAY 10 1983 REGISTRAR'S SIGNATURE J. C. L. L. L.					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 1 8 0 ED 9		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) THELMA GERTRUDE HAMILTON				2a. DATE OF DEATH MONTH DAY YEAR MAY 21, 1983		2b. HOUR 0940 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 746 E. Fort Ave. Baltimore, Md. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Austin C. Fout				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Ruby					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-52-3406		17. INFORMANT ADDRESS Mr. William C. Hamilton, Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/21 , 19 83 , to 5/21 , 19 83 , that (I) (we) last saw the deceased alive on 5/21 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. Mundy				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURYA P. MINDRA				22e. ADDRESS 203 E. PATAPSCO AVENUE BALTIMORE, MARYLAND 21225					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 25, 1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR McCutty Funeral Home, 130 E. Fort Ave. Baltimore, Md. 21230				25a. DATE REC'D. BY REGISTRAR MAY 23 1983		25b. REGISTRAR'S SIGNATURE Joan J. Gair			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of fact.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 3 1 1 8 1 0				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert L. Hance					2b. HOUR 5 19 83				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 3, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Port Republic		13e. STREET ADDRESS Box 163 20676			
14. FATHER'S NAME FIRST MIDDLE LAST Washington O. Hance					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Catterton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 217-44-3162		17. INFORMANT ADDRESS Octavia L. Hance same as # 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) Prostate CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4-25 19 83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-25 19 83 , to 5-19 19 83 , that (I) (we) last saw the deceased alive on 5-19 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE Raymond G. Herzinger MD.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-20-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond G. Herzinger						22e. ADDRESS 100 RIOGELY AVE ANNAPOLIS, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-23-1983		23c. NAME OF CEMETERY OR CREMATORY Assbury CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Barstow Calvert Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Donald V. Borgwardt Port Republic, Md. 20676						25a. DATE REC'D. BY REGISTRAR MAY 25 1983		25b. REGISTRAR'S SIGNATURE John J. Canine	



No. 1		Date		Locality	
1		1911		California	
2		1912		California	
3		1913		California	
4		1914		California	
5		1915		California	
6		1916		California	
7		1917		California	
8		1918		California	
9		1919		California	
10		1920		California	
11		1921		California	
12		1922		California	
13		1923		California	
14		1924		California	
15		1925		California	
16		1926		California	
17		1927		California	
18		1928		California	
19		1929		California	
20		1930		California	
21		1931		California	
22		1932		California	
23		1933		California	
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25		1935		California	
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27		1937		California	
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32		1942		California	
33		1943		California	
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61		1971		California	
62		1972		California	
63		1973		California	
64		1974		California	
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66		1976		California	
67		1977		California	
68		1978		California	
69		1979		California	
70		1980		California	
71		1981		California	
72		1982		California	
73		1983		California	
74		1984		California	
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85		1995		California	
86		1996		California	
87		1997		California	
88		1998		California	
89		1999		California	
90		2000		California	
91		2001		California	
92		2002		California	
93		2003		California	
94		2004		California	
95		2005		California	
96		2006		California	
97		2007		California	
98		2008		California	
99		2009		California	
100		2010		California	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 8 EDT 1 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) JAMES MANLEY HARGETT				2a. DATE OF DEATH MONTH DAY YEAR MAY 3, 1983		2b. HOUR 2 55 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 7, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (Ret.) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Elliott Truck-ing Co.	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Hargett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Green		13e. STREET ADDRESS 117 Stevens Rd. (21061)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214.14.4558		17. INFORMANT (Wife) ADDRESS Mrs. Janet M. Hargett Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auricular Fibrillation 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years 15 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (I) (this hospital) attended the deceased from 5.15.81 , 19____, to 4. 2, 1983 , 19____, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul Schonfeld M.D.				DEGREE M.D.		22c. DATE SIGNED 5-4-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL SCHONFELD, M.D.				22e. ADDRESS 407 CRAIN HIGHWAY STEFFY BUILDING GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7 May 83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD	
24. FUNERAL DIRECTOR NAME J. Coster				ADDRESS Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 6 1983	
				25b. REGISTRAR'S SIGNATURE John J. Carver			

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WAYNE COUNTY

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PAUL KLOPFER, M.D.

2. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 2597. 2598. 2599. 2600. 2601. 2602. 2603. 2604. 2605. 2606. 2607. 2608. 2609. 2610. 2611. 2612. 2613. 2614. 2615. 2616. 2617. 2618. 2619. 2620. 2621. 2622. 2623. 2624. 2625. 2626. 2627. 2628. 2629. 2630. 2631. 2632. 2633. 2634. 2635. 2636. 2637. 2638. 2639. 2640. 2641. 2642. 2643. 2644. 2645. 2646. 2647. 2648. 2649. 2650. 2651. 2652. 2653. 2654. 2655. 2656. 2657. 2658. 2659. 2660. 2661. 2662. 2663. 2664. 2665. 2666. 2667. 2668. 2669. 2670. 2671.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 1 1 8 1 2
REG. NO. EDT1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CATHALEEN MARIE HARTENSTEIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 4, 1983 | | 2b. HOUR
30 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 18, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
Domestic | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Glen Burnie | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John J. Hartenstein | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Matilda Wegartner | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-09-5233 | | 17. INFORMANT
ADDRESS
Rose M. Laage Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Brain Encephalopathy</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4100</u> weeks | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> , 19 <u>83</u> , to <u>5-4</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Sang C. Do</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5-5-83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SANG C. DOH, M.D. | | 22e. ADDRESS
95 AQUAHART ROAD
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/9/1983 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, A. A. Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME
McCutty Funeral Homes | | 24b. ADDRESS
BALTO. Md., 21225
237. E. Patapsco Ave., | | 25a. DATE REC'D. BY REGISTRAR
MAY 10 1983 | 25b. REGISTRAR'S SIGNATURE
<u>John J. Carver</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. 8 3 1 1 8 1 3 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
RALPH R. HASTE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
05 19 83 | | | 2b. HOUR
1:25 P.M. | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH MONTH DAY YEAR
04 27 27 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.
1 25 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1818 E. COPELAND STREET | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
GEORGE HASTE | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
FRANCES KINBELL | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W.II 220-167727 | | 17. INFORMANT ADDRESS
MARY HASTE 1818 E. Copeland St. Annapolis, Md. 21401 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CA Pharynx
1490
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Quethor H. Schwartz | | | | DEGREE
MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/19/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Quethor H. Schwartz | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
5-21-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
PINELAWN MEM. PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis A.A. Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM REESE & SONS MORTUARY, P.A. | | | | 24b. ADDRESS
Annapolis, Md. 21401 | | 25a. DATE RECD. BY REGISTRAR
MAY 25 1983 | | | |

MAY 20 1968
J. J. Smith

RECEIVED
MAY 20 1968
J. J. Smith

RECEIVED
MAY 20 1968
J. J. Smith

RECEIVED
MAY 20 1968
J. J. Smith

RECEIVED
MAY 20 1968
J. J. Smith

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MAY 20 1968
J. J. Smith

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MAY 20 1968
J. J. Smith

RECEIVED
MAY 20 1968
J. J. Smith

RECEIVED
MAY 20 1968
J. J. Smith

RECEIVED
MAY 20 1968
J. J. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 1 4
REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2b. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | MAY 19, 1983 | |
| GILBERT WILLIAM HATCH | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| MALE | | WHITE | | DEC. 19, 1912 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MARYLAND | | U.S.A. | | 70 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BROOKLYN PK. | | 642 SUNSET STRIP | | ANNE ARUNDEL COUNTY, MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 12c. STREET ADDRESS (21225) | |
| 13a. STATE | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? | |
| MARYLAND | | A.A. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| WILLIAM HATCH | | (UNKNOWN) | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (son) | | ADDRESS | |
| 212.07.7493 | | Mr. Terrill Hatch/Severn, MD | | 21144 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) | | Pulmonary Hypertension | | 3 Months | |
| DUE TO, OR AS A CONSEQUENCE OF | | Radiation therapy | | 1 year | |
| DUE TO, OR AS A CONSEQUENCE OF | | Squamous Cell lung Carcinoma | | 2 1/2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 19-Aug-82, to 17-May-83, that (I) (we) saw the deceased alive on 18-May-83, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| | | Richard E. Fisher M.D. | | 20-May-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| DR RICHARD E. FISHER | | 4700 PENNINGTON AVENUE/BALTO., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 23-May 83 | | LAKE VIEW MEM. PK. | |
| | | | | SYKESVILLE, CARROLL, MD. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SINGLETON FUNERAL HOME/GLENBURNIE, MD. | | MAY 20 1983 | | John J. Conish | |

100-100000-100000

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE



| DATE | TIME | LOCATION | REMARKS |
|------------|----------|-------------------|-------------------|
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |

| DATE | TIME | LOCATION | REMARKS |
|------------|----------|-------------------|-------------------|
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |
| 10-10-1964 | 10:10 AM | 100-100000-100000 | 100-100000-100000 |

100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-proper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|--|-------------------------------------|--|
| 1. FOR
STATE
REGISTRAR | | 7. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 5-2-83 | | 12:07 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| male | | Negro | | MONTH DAY YEAR | | 81 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| md | | U.S.A. | | | | A.A. Co | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| ANNAPOLIS | | ANNE ARUNDEL General Hospital | | retired | | custodian | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| md | | A.A. | | ANNAPOLIS | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 208 - Parker Ave 21401 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Talbert | | LOLA | | NO | | 213-160517 | | Margaret Toogood 807 Carrollton Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| 6000 | | | | renal failure | | obstructive uropathy | | benign prostatic hypertrophy | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4-25-83, to 5-2-83, that (we) last saw the deceased alive on 4-29-83, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| | | MD | | | | 5-2-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| G Mitchell MD | | 205 Bridgely Ave Annapolis | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN COUNTY STATE | |
| Burial | | May 7-83 | | Mt. Calvary | | A.A. md | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25. DATE REC'D. BY REGISTRAR | | 25. REGISTRAR'S SIGNATURE | |
| C.E. Hicks | | 1922 Forest Drive | | ANNAPOLIS | | MAY 9 1983 | | John J. Connel | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3

REG. NO.

1 1 8 1 6

EDT

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HELEN E HILL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 28, 1983 | | 2b. HOUR
710 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
May 7, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Line Operator-W. | | 12b. KIND OF BUSINESS OR INDUSTRY
R. Grace Co. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
8481 Bedford Road 21122 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
? Bridges | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen K. Buhl | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-20-9358 | | 17. INFORMANT
ADDRESS
Pasadena, Md.
Mr. Gilbert W. Hill 8481 Bedford Rd. 21122 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure and Liver Failure
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) Liver metastasis
DUE TO, OR AS A CONSEQUENCE OF
(c) Colon Cancer | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 d
10 month
1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Anemia and thrombocytopenia; malnutrition | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10 , 19 83 , to 5-28 , 19 83 , that (I) (we) last saw the deceased alive on 5-28 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Long S. Hsu | | DEGREE
MD | | 22c. DATE SIGNED
5-28-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LONG S. HSU, M.D. | | 22e. ADDRESS
7845 OAKWOOD ROAD, SUITE 104
GLEN BURNIE, MD. 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
June 1, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie Anne Arundel Md. | |
| 24. FUNERAL DIRECTOR
Mc Culley Funeral Home of Pasadena | | 25a. DATE REC'D. BY REGISTRAR
2122 JUN 2 1983 | | 25b. REGISTRAR'S SIGNATURE
Joan J. Gough | |

The Cylindropuntia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 83 | | 11817 | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
MYRTLE G HINES | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-9-83 | | | | 2b. HOUR
700 A.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
FEB 8 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
EDGEWATER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PLEASANT LIVING NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY
C&P TELEPHONE | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
GALESVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
FRANK GROFF | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
BERTHA SAGER | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) | | | |
| 16a. SOCIAL SECURITY NO.
578-14-2848 | | 17. INFORMANT ADDRESS
RICHARD G. HINES ARNOLD, MD 21012 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEART FAILURE
4289
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
EMMED | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-14, 1983, to 5-9, 1983, that (I) (we) last saw the deceased alive on 4-28, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Charles W. Kinzer, M.D. | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-9-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES W KINZER MD | | | | 22e. ADDRESS
16 MURRAY AVE ANNAP MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5/11/83 | | 23c. NAME OF CEMETERY OR CREMATORY
HILLCREST CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ANNAPOLIS A.A. MD | | | |
| 24. FUNERAL DIRECTOR NAME
HARDESTY FUNERAL HOME 12 RIDGELY AVE., ANN, MD | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 13 1983 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 1 8
REG. NO. ED

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | MAY 8, 1983 | | 1215 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | Oct. 9 1903 | | 79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Balto. Md. | | U.S.A.. | | | | ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Driver | | Monarch Fds. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md | | A.A. | | Glen Burnie | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| John | | Maude | | No | | 215-03-5856 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| Mr. Lawrence (son) Hinks | | 4100 | | | | | |
| 51 Sunset Dr. Severna Park, 21146 | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterial Disease</u> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | |
| | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | |
| | | | | | | 21e. PLACE OF INJURY | |
| | | | | | | 21f. LOCATION | |
| | | | | | | 22a. I certify that (I) (this hospital) attended the deceased from <u>5-2</u> , 19 <u>83</u> , to <u>5-8</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5-8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | |
| | | | | | | 22b. SIGNATURE | |
| | | | | | | 22c. DATE SIGNED | |
| | | | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| | | | | | | 22e. ADDRESS | |
| | | | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | |
| | | | | | | 23b. DATE | |
| | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | |
| | | | | | | 23d. LOCATION | |
| | | | | | | 24. FUNERAL DIRECTOR | |
| | | | | | | 25a. DATE REC'D. BY REGISTRAR | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | 26. NAME | |
| | | | | | | 27. ADDRESS | |
| | | | | | | 28. CITY OR TOWN | |
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| | | | | | | 30. STATE | |
| | | | | | | 31. ZIP CODE | |
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DR. HILARY T. O'NEILL
Singleton Funeral Home Glen Burnie Md.

325 HOSPITAL DRIVE, SUITE 208
GLEN BURNIE, MARYLAND 21061
MAY 10 1983 John J. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 signed as any injury, or other traumatic event, the medical examiner must be notified by one.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 | 3 | 1 | 1 | 8 | 1 | 9 |
|--|--|---|--|---|--|---|--|--|--|--|---|---|---|---|---|---|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES CHESLEY HOLT JR. | | | | | | 2a. DATE OF DEATH
MONTH MAY DAY 25 YEAR 1983 | | | | 2b. HOUR
M | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MARCH 28 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Arundel General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FROM MOST OF WORKING LIFE)
SHEET METAL | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STATE
MD. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
GLENDALE | | | | | | |
| 14. FATHER'S NAME
FIRST JAMES MIDDLE CHESLEY LAST HOLT | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST JESSIE (NA) MIDDLE SEYMOUR LAST | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 2 | | 17. INFORMANT
MARY HOLT (SAME AS # 13) | | ADDRESS
6417 GLENN DALE RD. 20769 | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) CARDIAC ARREST. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) CORONARY HEART DISEASE. | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 5-4- 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we last did not view the body after death.) | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Chaudhey MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
5/27/83 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. CHAUDHEY | | | | | | 22e. ADDRESS
SUITE # 100
14201 LAUREL PK. DR. LAUREL MD. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
31MAY83 | | 23c. NAME OF CEMETERY OR CREMATORY
MD. VETRANS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CHELLENHAM P.G. MD. | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
HALES Lanham F.H. 9013 ANnapolis Rd Lanham MD. | | | | | | ADDRESS
9013 ANnapolis Rd Lanham MD. | | 25a. DATE REC'D. BY REGISTRAR
JUN 3 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 2 0
REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
PAUL FRANK HORAK | | | | 2a. DATE OF DEATH MONTH DAY YEAR
APRIL 18, 1983 | | | |
| 3. SEX
MALE | | | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
AUGUST 14, 1920 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
QUALITY CONTROL | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12b. KIND OF BUSINESS OR INDUSTRY
GOULD GOV'T. SYS. | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
GLEN BURNIE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
PAUL HORAK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
EMILY UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WW II | | | |
| 16b. SOCIAL SECURITY NO.
175-16-6848 | | 17. INFORMANT
RENA HORAK | | ADDRESS
(SAME AS 13) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocardial infarction sudden death
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 7/15 19 56 to Apr. 18 19 83 , that (I) (we) last saw the deceased alive on FEB 22 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Joseph Taler, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
Apr. 19, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH TALER | | | | 22e. ADDRESS
954 Parkhart Rd. Glen Burnie, Md. 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
APRIL 21, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
HILLCREST CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ANNAPOLIS ANNE ARUNDEL MD | |
| 24. FUNERAL DIRECTOR NAME
ROBERT S. BARRANCO | | | | 25. DATE REC'D. BY REGISTRAR
APR 22 1983 | | | |
| ADDRESS
501 RITCHIE HWY SEVERNA PARK, MD | | | | REGISTRAR'S SIGNATURE
J. C. Carrick | | | |

BP



20% COLLOID



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M/181
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 2 1

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Elmer FRANCIS HORN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 20 1983 | | | 2b. HOUR
7:45 A M | | | |
| 3. SEX
MALE | | 4. RACE
CAU. | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 25 98 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
CROWNSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FAIRFIELD NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TRUCK DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Edgewater | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1640 MARLBORO Rd. 21037 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNK. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNK. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yea | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
1918 | | 17. INFORMANT
Richard Clabo | | ADDRESS
1640 Marlboro Rd. Edgewater Md 21037 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emphysema
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Bronchitis
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized atherosclerosis | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Yrs
Yrs
Yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
1) CVA 2) S/P Bowel infarction & resection | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from 19 28 to 5/20 , 19 83 , that (1) (we) lost
saw the deceased alive on 5/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Joseph N. Friend M.D. | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
5/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph N. Friend | | | | 22e. ADDRESS
205 Ridgely Ave. Annapolis, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
5-21-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
T.A. Hardesty | | | | ADDRESS
ANNAPOLIS MD, 21041 | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Casper | |

MEDICAL CERTIFICATION

11/11



11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 3 1 1 8 2 2
REG. NO. DST |
|---|--|--|--|--|--------|--|----------------------------------|---|--|-------------------------------|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR am M | |
| | | CHARLES E HOSKINS | | | | | MAY 28, 1983 | | 10:10 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| M | | W | | 07 21 14 | | 68 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| TEXAS | | U.S.A. | | | | ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | RETIRED - SUNPAPERS | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | |
| MD. | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1027 CATHEDRAL ST. - 8G 21201 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| Unkn. | | 441-26-2122 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4960 IMMEDIATE CAUSE (a) Cardiac failure shock | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| (b) Advanced ASCVD | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) Advanced COPD | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/27/1983 to 5/28/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE RECEP EROL, M.D. | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS 325 HOSPITAL DRIVE, #104 GLEN BURNIE, MD. 21061 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Removal | | 5/30/83 | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Anatomy Board | | | | Balto., Md. | | JUN 3 1983 | | John J. Conner | | |

BP

5 5 1 1 5 0 8

RECEIVED
JAN 10 1950

107

CHIEF OF BUREAU

RECEIVED



JAN 10 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 2 3
REG. NO. | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| 1. DECEASED NAME FIRST MIDDLE LAST
ANTOINETTE MARIE HUNGELMANN | | | | 5/3/83 | | | | A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
3 28 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
421 Phirne Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Muth | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
216-40-0838 | | 17. INFORMANT ADDRESS
Walter A. Hungelmann 421 Phirne Road 21061 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of The Colon</u>
1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> , 19 <u>83</u> , to <u>5/2</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>5/22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Glenn F. Robbins</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/3/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Glenn F. Robbins | | | | 22e. ADDRESS
1404 Crain Highway South Suite 300 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
5/5/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 24b. ADDRESS
21229 | | 25a. DATE REC'D. BY REGISTRAR
MAY 4 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Connel</u> | |

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 1.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 3 1 1 8 2 4
REG. NO. | |
|--|--|---|--|---|---------------------------|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | |
| ELMER GILROY HUNT | | | | 2a. DATE OF DEATH
MAY 26, 1983
05 26 83 | | 2b. HOUR
5:30 A.M. |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 27, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen'l. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Chief Draftsman | | 12b. KIND OF BUSINESS OR INDUSTRY
Corp. of Eng. |
| 13a. STATE
Maryland | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elmer Clinton Hunt | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Keziah Ellen Barnes | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
W.W. II 218.01.5295 | | 17. INFORMANT (wife) ADDRESS
Mrs. Lois M. Hunt Same as # 13 | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>left ventricular failure</u>
4100
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Unknown</u>
<u>Unknown</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/26/83</u> to <u>5/26/83</u> , that (I) (we) last saw the deceased alive on <u>5/26/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Max C Frank MD</u> | | | | DEGREE
MD | | 22c. DATE SIGNED
5/26/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MAX C FRANK MD | | | | 22e. ADDRESS
7575 Ritchie Hwy - Glen Burnie MD 21061 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
28 May 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem.Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, A.A. MD |
| 24. FUNERAL DIRECTOR
NAME
J. Shannon Easter | | | | ADDRESS
-21061- | | 25a. DATE RECEIVED BY REGISTRAR
MAY 31 1983 |
| SINGLETON FUNERAL HOME/GLEN BURNIE, MD. | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 2 5
REG. NO. | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILL | | | | FIRST MIDDLE LAST HUNTER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 22 83 | | | | 2b. HOUR 6⁰⁰ AM | |
| 3. SEX Male | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR 1 17 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNAPOLIS CONVALESCENT CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 130 Hearn Rd. Apt. 915 21401 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST VICTOR HUNTER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MENERYA FRENANDUS | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 227-10-9037 | | 17. INFORMANT ADDRESS EVELYN HUNTER 130 Hearn Rd. Apt. 915 | | | | Annapolis, Md. 21401 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 3109 DEMENTIA
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Brain Syndrome; Strokes
DUE TO, OR AS A CONSEQUENCE OF (c) 5 years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) Pneumonia - dehydration. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1975 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE Present | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5-13-83 to 5-22-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Peter F. VerKouwen | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-22-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUWEN | | | | 22e. ADDRESS 1419 Forest Dr. Annapolis, Md 21403 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-26-1983 | | 23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A. | | | | Annapolis, Md. 21401 | | | | 25. DATE RECEIVED BY REGISTRAR MAY 25 1983 | | | | | |

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502-01-52

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 3 1 1 8 2 6 | |
|--|--|---|--|---|---|--|---|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
RUTH Viola JACKSON | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 1 83 | | | 2b. HOUR
6 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 28, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Dickeyville, MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland Manor | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Laundry Worker | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
101 N. Meadow Drive 20161 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nelson Widerman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katie Schlag | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-03-3243 | | 17. INFORMANT
ADDRESS
Ethel M. Miles, Same as 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
5990 IMMEDIATE CAUSE (a) <u>Septo - CHF</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UTI</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-20, 19 82</u> to <u>5-1, 19 83</u> that (I) (we) lost
saw the deceased alive on <u>4-30, 19 83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> DEGREE | | | | | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | | | 22c. DATE SIGNED
5-1-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL B. PEARLMAN | | | | | | 22e. ADDRESS
5400 OLD COURT RD. BALTIMORE MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3 May 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | | |
| 24. FUNERAL DIRECTOR
NAME
James S. Kirkley, Glen Burnie, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 2 1983 | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

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RECEIVED
MAY 2 1963

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Handwritten notes and a large scribble covering the middle section of the page.

Handwritten text at the bottom of the page, including the date MAY 2 1963.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 2 7
REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH D. JOHNSON | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 18 83 | | | | 2b. HOUR
1:50 PM | |
| 3 SEX
Male | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12- 13 - 09 | | 6 AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
A.A. County MD. | | | |
| 10 CITY OR TOWN OF DEATH
Crownsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Crownsville Hospital Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
custodian | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Balt. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5904 Bell Grove Road 21225 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
JULIUS JOHNSON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY THOMPSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
unknown | | | | 16b. SOCIAL SECURITY NO.
174-14-2368 | | 17 INFORMANT
ADDRESS
RUFUS JOHNSON 3913 CHATHAM RD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Failure
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
b Generalized Arterio-Sclerosis & ASCVD
DUE TO, OR AS A CONSEQUENCE OF
c History of Chronic Bronchitis & decubitus ulcer. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hour
3 years
5 mos. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-18 , 19 83 , to 5-18 , 19 83 , that (I) (we) last saw the deceased alive on 5-18 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Nureddin Erk M.D. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
5-18-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Nureddin Erk, M.D. | | | | 22e. ADDRESS
Crownsville Hosp. Center, Md. 21032 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/24/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
LEORY O. DYETT 4600 Liberty Hqts. Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 20 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |



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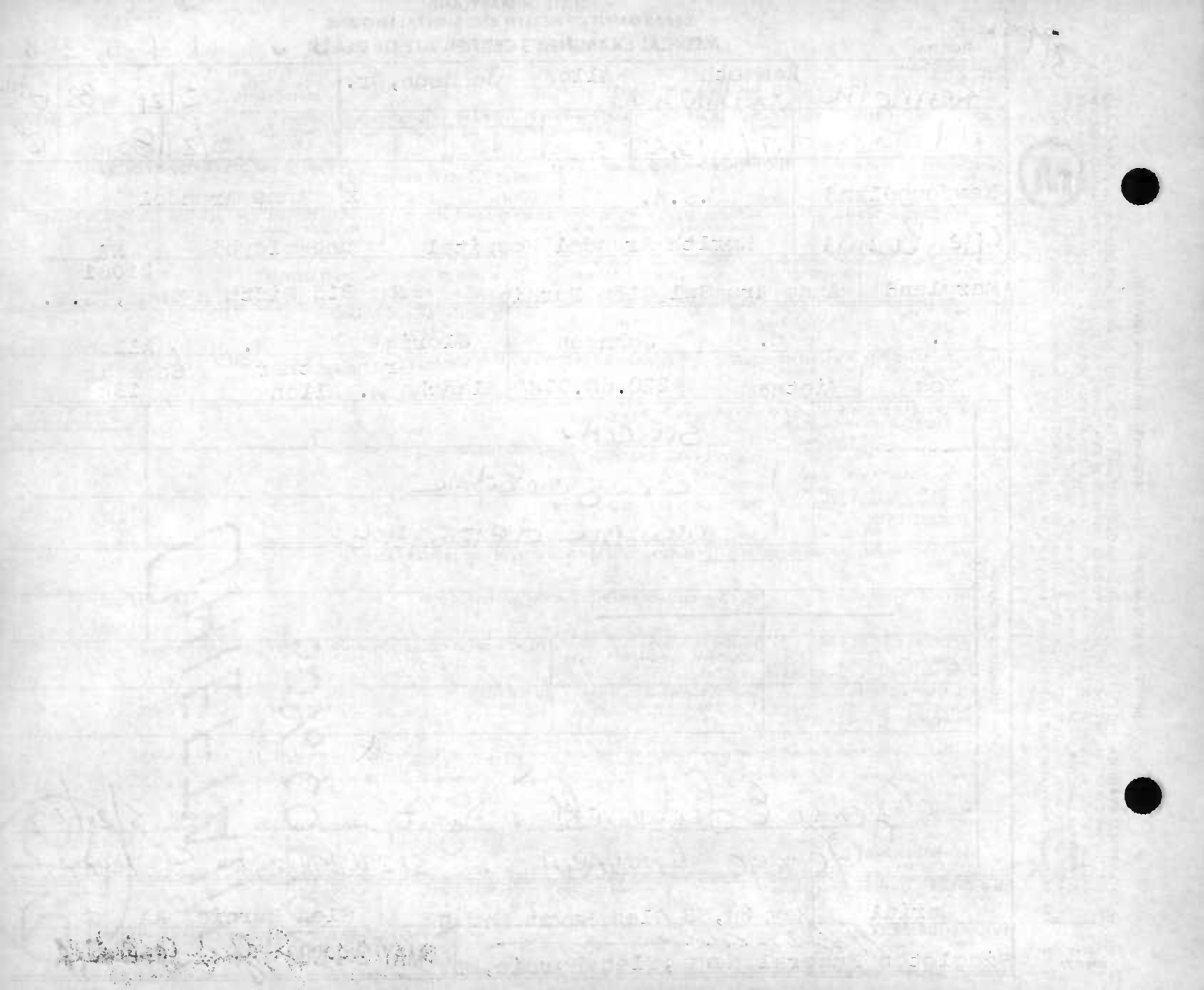
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17
(VR A15 ME (5))
15M/77

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 1 8 2 8 | | | | | |
|--|--|--------------|--|---|--|---|--|--|--|--|--|--|--|----------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 7a. DATE KNOWN OF DEATH | | 7b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Kenneth Allen Johnson, Sr. | | | | | | | | | | DATE ESTI-MATED 5/21/83 | | 19 83 6 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH (MONTH DAY YEAR) | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| Male | | White | | July 15, 52 | | 30 YRS | | | | | | 5/21/83 19 | | 12 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Newfoundland | | | | U.S.A. | | | | | | | | Anne Arundel MD | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Glen Burnie | | | | North Arundel Hospital | | | | unemployed | | | | NA | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21061 | | | | | | | |
| Maryland | | Anne Arundel | | Glen Burnie | | | | 315 Fifth Avenue, S.E. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | |
| A. C. Johnson | | | | Gloria M. Allen | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| Yes | | | | Vietnam | | | | 220.60.7740 | | | | Blanche M. Allen | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Suicide</u>
9505
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <u>drug overdose</u>
(c) <u>manic depression</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>George E. Linhardt</u> | | | | TITLE (SPECIFY) <u>Deputy</u> | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5/21/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>George Linhardt</u> | | | | ADDRESS <u>312 Washington St. Annapolis</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | May 24, 83 | | | | Glen Haven Mem pk | | | | Glen Burnie AA MD | | | |
| 24. FUNERAL DIRECTOR NAME <u>AB V...</u> | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Singleton Funeral Home, Glen Burnie, MD | | | | MAY 24 1983 | | | | <u>John J. Carver</u> | | | | | | | |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11829

| | | | | | |
|--|---------|---|-------------------|--|--|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Ernest E. Jones | | 5/23/83 | | 6:30 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| M | B | 05 24 29 | 53 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Washington, D.C. | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Annapolis | | Anne Arundel Gen. | | Farmer | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md | | Anne Arundel | | Friendship | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. SOCIAL SECURITY NO. | |
| Willie Jones | | Lillian Maynard | | 216-28-1132 | |
| 16b. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 17. INFORMANT | | ADDRESS | |
| yes | | Rebecca C. Jones | | 80 Sandsbury Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | |
| 4292 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| George E. Duhaime | | M.D. Dep. | | 5/24/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| George E. Duhaime | | 312 Washington St. Annapolis | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | May 27-83 | | Carters Chr. Cem. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME | | ADDRESS | | | |
| Spencer E. Sewell | | Box 31, Prince Frederick, Md | | MAY 31 1983 | |

• • •

4111e

3015514

SC 1-86-24

S. 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 3 0
REG. NO. DST |
|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR |
| IDA MAE KELLEY | | | | MAY 11, 1983 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7b. HOUR |
| Female | White | October 17, 1903 | 2 82 X YRS. | 10:38A M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| West Virginia | USA | | ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Housewife | |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS |
| West Virginia | | Wyoming | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | Box 134 24874 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | |
| Will Wyatt | | Mary Miller | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| No | | 232-96-5191 | Roger L. Bowman, 12 Harriett Drive, Glen Burnie | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>arteriosclerotic cardiovascular disease</i> | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>Burnie</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<i>Jose M. Presbitero M.D.</i> | | 22c. DATE SIGNED
5/11/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | |
| JOSE M. PRESBITERO, M.D. | | 7845 OAKWOOD ROAD, #107
GLEN BURNIE, MARYLAND 21061 | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | 14 May 1983 | Palm Memorial Gardens | Matheny West Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | |
| James S. Kirkley, Glen Burnie, MD | | MAY 16 1983 | | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 3 1

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RAYMOND H. KENDALL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 10 83 | | 2b. HOUR
8:30 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
5 2 24 | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Boiler Repairman | | 12b. KIND OF BUSINESS OR INDUSTRY
B.G. & E. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-20-4702 | 17. INFORMANT
ADDRESS
Doris K. Kendall 230 Magothy Beach Rd. 21122 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm
4413
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Pt also had lung cancer and
DUE TO, OR AS A CONSEQUENCE OF
(c) Brain metastases
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours
4 mo. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/11 19 83 , to 5/11 19 83 , that (I) (we) last saw the deceased alive on 5/4 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Wm C Waterfield MD | | DEGREE | | 22c. DATE SIGNED
5/11/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William C. Waterfield, MD. | | 22e. ADDRESS
St. Agnes Hosp. Oncology Dept. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
5/13/83 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | 25a. DATE REC'D. BY REGISTRAR
MAY 11 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Canine | |

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35
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1
9
9
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



CHEE M

20% COTTON



Handwritten signature or mark.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 11832 | | | |
|--|--|----------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Henry E. King, Jr. | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR MAY 28, 1983 | | 2b. HOUR 11:58 AM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH (MONTH DAY YEAR) 07 07 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MAY 28, 1983 | | 2d. HOUR 11:58 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Admn. Officer | | | | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't. | | | |
| 13a. STATE WASH DC | | | | 13b. COUNTY 20015 | | 13c. CITY OR TOWN Washington, DC | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5400 31st N.W. | | | | 99999 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Henry E. King | | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Ruth ** Hutchinson | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 213-46-5122 | | 17. INFORMANT ADDRESS Nancy D. King, Same address as #13. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) CARDIAC ARREST
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) ASCD.
(c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
SIP CVA. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE George E. Linhardt | | | | TITLE (SPECIFY) M.D. Dep. | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5/28/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) G. LINHARDT | | | | ADDRESS 312 WASHINGTON ST. ANN. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 6/1/83 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1983 | | | | | | REGISTRAR'S SIGNATURE John J. Gawler | | | |
| 5130 Wisconsin Ave, NW, Washington, D.C. 20016 | | | | | | | | | | | | | | | |

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR
1 - STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 3 3
REG. NO. | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Joan E. Klang | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5-15-83 | | | | 2b. HOUR
4 ¹⁵ M | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
11-17-23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
ENG | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A. Co MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A.A. GEN. Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NURSE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOSP. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md 13b. COUNTY A.A. 13c. CITY OR TOWN SEVERNA Pk | | | | | | 14. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1 Madary Rd 21146 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Tully | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Heddy Drummond | | | | | |
| 16a. WAS DECEASED EVER IN THE ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
005-24-8731R | | 17. INFORMANT
ADDRESS
Wm. Klang - Above | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4280 Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Acute abdomen, chronic progressive heart failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (if this hospital) attended the deceased from 5-14-83 to 5-15-83, that (we) lost saw the deceased alive on 5-15-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
G Mitchell MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-15-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G Mitchell MD | | | | | | 22e. ADDRESS
205 Ridgely Ave, Annapolis Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
5/16/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Westmoreland | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore | | | |
| 24. FUNERAL DIRECTOR
NAME
Charles S. Bananas | | | | | | ADDRESS
Severna Pk | | 25a. DATE REC'D. BY REGISTRAR
MAY 18 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 83 | 11834 | | |
|--|--|--|--|--|--------------------------|---|----------------------------|--|-----------------------------------|---|-------|------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 20. DATE OF DEATH | | | | | 2b. HOUR | | | |
| WILLIAM STERLING KNOPP | | | | | MAY 5, 1983 | | | | | 1048A ^M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| MALE | | CAUC. | | MARCH 7, 1921 | | 62 | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | MD. | | |
| Maryland | | USA | | | | ANNE ARUNDEL | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| ANNAPOLIS | | ANNE ARUNDEL GEN. HOSP. | | | | Real Estate | | | Post Office | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Box 501 Deale Rd 20251 | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Charles S Knopp | | | | | Glady's Marshall | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| Yes | | | | | 15-18-504 | | Corinna W Knopp same as #3 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | IMMEDIATE | | | |
| IMMEDIATE CAUSE (a). 4100 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| HYPERTENSION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from MARCH 6, 1974 to MAY 5, 1983, that (I) (we) lost saw the deceased alive on MAY 3, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| Charles W. Kinzer | | | | | | | | | | May 5, 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e. ADDRESS | | | | | |
| CHARLES W. KINZER MD | | | | | | | | 16 MURRAY AV., ANNAPOLIS, MD 21401 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | |
| Burial | | | | 5-9-83 | | Maryland Veterans Cemetery | | | Cheltenham AG MD | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | 25. DATE REC'D. BY REGISTRAR | | | | | |
| Rousch Funeral Home | | | | | | | | MAY 11 1983 | | | | | |
| 26. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| John P. C | | | | | | | | | | | | | |

BP

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

William F. Lee, Jr.
MAY 2 1963 10:10 AM

MALE
CAUC
MARCH 1914 62
X
AND ARROW

APPROXIMATELY 5' 10" TALL
WEIGHT 170 LBS.

HAIR BROWN
EYES BROWN

ACTED IN A MANNER
UNUSUAL

EXPERIENCE

EDUCATION

EMPLOYMENT

CHARACTER

REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 3 1 1 8 3 5 | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 7b. HOUR | | | |
| ERNEST H. KRUTZFELDT | | | | MAY 27, 1983 | | | | 9:15A M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | Caucasian | | August 23, 1904 | | 78 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Germany | | USA | | | | ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | Tavern Owner | | Retired | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | AA | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 108 Eastern Street, 21061 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Arthur J. Krutzfeldt | | | | Magda Lorenzen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | 078-10-7510 | | Greta Homens, daughter, 841 White Ave. 21090 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Valvular pathology, cardio-respiratory arrest.</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 1579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary heart disease.</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Perforated gastro-jejunum.</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 5.22.83 | | Perforated gastro-jejunum | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5.22</u> , 19 <u>83</u> , to <u>5.27</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>5.22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <u>Arsenio Santos</u> | | | | | | | | 5.27.83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| ARSENIO SANTOS, M.D. | | | | 7845 OAKWOOD ROAD, #205 GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | 31 May 83 | | Glen Haven Mem. Pk. | | Glen Burnie, AA Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| James S. Kirkley, Glen Burnie, Maryland | | | | JUN 2 1983 | | | | <u>John J. Connel</u> | | | |

BP _____























Handwritten signature and date: *John S. [illegible]* JUN 2 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 3 1 1 8 3 6 EST | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | 2b. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| OLIVER FRANKLIN LAING | | | | | | MAY 6, 1983 | | 605 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | White | | March 22, 1917 | | 66 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | Truck Driver | | Trucking | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | | Anne Arundel | | Odenton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13e. STREET ADDRESS | | | |
| Oliver Laing | | | | Myrtle Lilley | | 1312 Chapelview Dr. 21113 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No. | | 218-18-3068 | | Helen M. Laing | | same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4600 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CO₂ NARCOSIS</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>ADVANCED C.O.L.D. (chronic obstructive lung disease)</u> | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/24/1983</u> to <u>5/06/1983</u> , that (I) (we) last saw the deceased alive on <u>5/06/1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>K. Dharma Sena</u> | | | | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>5/06/1983</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>K. DHARMASENA, M.D.</u> | | | | 22e. ADDRESS <u>8 16TH AVENUE BALTIMORE, MARYLAND 21225</u> | | | | | |
| 23b. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5/9/83</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Highland, Howard, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>FLECK FUNERAL HOME, INC.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 10 1983</u> | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | | |
| 7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | | | | | | |

| | | | |
|--|--|--|--|
| <div data-bbox="16 13 243 134">  </div> | | <div data-bbox="1380 13 1607 134">  </div> | |
| <div data-bbox="16 134 243 268">  </div> | | <div data-bbox="1380 134 1607 268">  </div> | |
| <div data-bbox="16 268 243 403">  </div> | | <div data-bbox="1380 268 1607 403">  </div> | |
| <div data-bbox="16 403 243 537">  </div> | | <div data-bbox="1380 403 1607 537">  </div> | |
| <div data-bbox="16 537 243 672">  </div> | | <div data-bbox="1380 537 1607 672">  </div> | |
| <div data-bbox="16 672 243 806">  </div> | | <div data-bbox="1380 672 1607 806">  </div> | |
| <div data-bbox="16 806 243 940">  </div> | | <div data-bbox="1380 806 1607 940">  </div> | |
| <div data-bbox="16 940 243 1075">  </div> | | <div data-bbox="1380 940 1607 1075">  </div> | |
| <div data-bbox="16 1075 243 1209">  </div> | | <div data-bbox="1380 1075 1607 1209">  </div> | |
| <div data-bbox="16 1209 243 1330">  </div> | | <div data-bbox="1380 1209 1607 1330">  </div> | |

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 3 7 |
|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MINNIE (nmn) LA MARTINA | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
May 20, 1983 M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 22, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Colorado | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
404 Packer Ave. (Ferndale) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress
12b. KIND OF BUSINESS OR INDUSTRY
Haas Cloth. | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | |
| 13c. CITY OR TOWN
Glen Burnie | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Pasquale LaMartina | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marian Camlerri | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
No N/A | | 16b. SOCIAL SECURITY NO.
A
213-09-5751 | | 17. INFORMANT (Sister) ADDRESS
Same As #13
Miss Catherine LaMartina #13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Advanced Parkinsonian Syndrome</u>
3320
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic neuromuscular complications</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Reduced nutrition & hydration</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
<u></u> |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1943</u> , 19 <u>83</u> , to <u>20 May</u> , 19 <u>83</u> , that (I) (we) lost
saw the deceased alive on <u>20 May</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
OF PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. William J. Bryson | | 22c. ADDRESS
5772 Westview Mall | | 22d. DATE SIGNED
23 May 83 |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Entombment | | 23b. DATE
May 24 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1983 | | |
| 24. FUNERAL DIRECTOR
NAME
B. N. Hopkins | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 3 8
REG. NO. EDT

| | | | | | | | | | |
|---|---|---|-------------------|--|--|--|--|------|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| MARY ANN LOHMAN | | | | | MAY | | 1, | 1983 | 1155 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | White | July 15, 1906 | | 76 | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pennsylvania | U.S.A. | | | ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YEARS) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | | Statician (ret) | | Tea Co. A.&P. | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | 21061 | | |
| Maryland | | Arundel | Glen Burnie | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 379 Phirne Road | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Patrick Cline | | Ellen Kennedy | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Sister) | | ADDRESS | | | |
| No | | N/A | | Miss. Nora F. Cline | | 62 Hayes Rd. Chapel Hill, N.C. 27514 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 mo.</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-1-83</u> to <u>5-1-83</u> , that (I) (we) last saw the deceased alive on <u>5-1-83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| <u>Jack I. Stern</u> | | 5-2-83 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE SIGNED | | 22g. REGISTRAR'S SIGNATURE | | | |
| JACK I. STERN, M.D., P.A. | | 300 HOSPITAL DRIVE, SUITE 135
GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | May 5, 1983 | | Mt. Olivet Cem. | | Carnegie, Allegheny Pa. | | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Singleton Funeral Home, Glen Burnie, Md | | MAY 3 1983 | | <u>John J. Conner</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

DATE: MAY 1, 1901
TO: THE SECRETARY OF AGRICULTURE
FROM: J. H. HARRIS

SUBJECT: [illegible]

REFERENCE: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11839 | |
|---|--|-------------------------|--|---|---|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Frank Fred Lucchesi | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH 5 DAY 5 YEAR 1983 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 7 DAY 20 YEAR 13 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YR.
MONTHS 0 DAYS 0 HOURS 0 MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH 5 DAY 5 YEAR 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH
Severna Park | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
218 Kennedy Drive | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Cab driver | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Penna. | | | 13b. CITY OR TOWN
Wyndmoor | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1145 Pleasant Ave. | | | |
| 14. FATHER'S NAME
FIRST Antonio MIDDLE Lucchesi LAST Lucchesi | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Domènica MIDDLE Aloi LAST Aloi | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO.
182-01-7808 | | 17. INFORMANT
218 Kennedy Dr. Dr. Diane Householder Severna Pk, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4280 IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) Hiatal Hernia
DUE TO, OR AS A CONSEQUENCE OF
(c) Hiatal Hernia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Hiatal Hernia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Richard E. Cook | | | | M.D. Sub. Dep. | | | | MEDICAL EXAMINER DATE SIGNED 5/5/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Richard E. Cook, M.D. | | | | ADDRESS 113 Cathedral St, Annap., Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-10-83 | | 23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul | | | 23d. LOCATION
CITY OR TOWN Springfield, Delaware COUNTY Penna. STATE | | |
| 24. FUNERAL DIRECTOR
NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 6 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Cook | | | |



Richard E. Cook

Leonard J. Wood, Inc. Baltimore, Md.
WATSON & CO. NEW YORK
Baltimore, Md. 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 354-1200.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 3 1 1 8 4 0 | | DST | |
|--|--|--|---|---|---|---|--|--|--|--------------------------------|------------------|-----|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EDNA Ann MABRY | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 29, 1983 | | | | | 2b. HOUR P.
12:35 M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 3 1944 | | 6. AGE (IN YEARS LAST BIRTHDAY)
39 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sect. | | | 12b. KIND OF BUSINESS OR INDUSTRY
US Gov. | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
AACo. | | 13c. CITY OR TOWN
Odenton | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
588 Rita Dr. | | 2/113 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elmer Presley | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Mitchell | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
205348691 | | 17. INFORMANT
James Mabry | | | ADDRESS
Same as #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage
1952
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Abdominal carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
3 months | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Intestinal obstruction | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
4/21/83 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intestinal obstruction | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-15 , 19 83 , to 5-29 , 19 83 , that (I) (we) lost saw the deceased alive on 5-29 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Long S. Hsu | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LONG S. HSU, M.D. | | | | | 22e. ADDRESS
7845 Oakwood Road, #104
Glen Burnie, Maryland, 21061 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
6-1-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Nichols Bethel Church Cem. Odenton AACo. Md. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | | | | ADDRESS
Annapolis Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | |

BP _____

40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove corpanpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|--|
| 1. STATE REGISTRAR | | | REG. NO. 8311841 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
FRANK (nmi) MALANTRUCOLO | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 15, 1983 | | | | 2b. HOUR
6:00a M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
8/16/1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ROME, ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A. CO. MD. | | | | |
| 10. CITY OR TOWN OF DEATH
MILLERSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
569 BRIGHTWOOD ROAD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SUPERVISION | | 12b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
MILLERSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
569 BRIGHTWOOD ROAD 21108 | | |
| 4. FATHER'S NAME FIRST MIDDLE LAST
UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
236.01.9414 | | 17. INFORMANT ADDRESS
JULIA J. MALANTRUCOLO SAME AS 13e. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute heart failure
2500
DUE TO, OR AS A CONSEQUENCE OF, (b) Diabetes mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF, (c) Hyper tension A-I. C. V. D. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4-1 , 19 69 , to 3-13 , 19 83 , that (1) (we) last saw the deceased alive on 3-13 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Robert Dabolins, M.D. DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/16/1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT DABOLINS, M.D. | | | | | | 22e. ADDRESS
400 CRAIN HGHY. N.W. GLEN BURNIE, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
5/16/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT CEMETARY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
WALTER BROOKS BRADLEY, INC., BALTO., MD. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1983 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

1007 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES VINCENT MALANTRUCOLO | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 24, 1983 | | | 2b. HOUR
7:15a M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
4/30/1931 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PHILA., PENN. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
MILLERSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
569 BRIGHTWOOD ROAD 21108 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SELF EMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY
TELEVISION TECHNICIAN | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
MILLERSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK MALANTRUCOLO | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JULIA TRANO | | 13e. STREET ADDRESS
569 BRIGHTWOOD ROAD 21108 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
KOREA
172.24.5349 | | 17. INFORMANT ADDRESS
ROBERTA M. MALANTRUCOLO SAME AS 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1579 IMMEDIATE CAUSE (a) DISSEMINATED PANCREATIC CANCER
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
David A. Van Echo MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/24/1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID A. VAN ECHO, MD | | | | 22e. ADDRESS
22 So Greene St, Balto, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
5/25/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1983 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Joan J. Connel | | | | | | | | | |

BP

MADE IN U.S.A.

100% COTTON

MADE IN U.S.A.

100% COTTON



100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 4 3
REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Randolph Manns | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-13-83 | | | 2b. HOUR
3:25 AM | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH MONTH DAY YEAR
4-27-25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
SEVERNA PARK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 14. STREET ADDRESS
311 Ritchie Highway 21146 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK JENNINGS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH MANNS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W.II | | 17. INFORMANT ADDRESS
GENEVA MANNS 311 Ritchie Highway 21146 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Transitional Cell Carcinoma
1991
DUE TO, OR AS A CONSEQUENCE OF
(b) Left Nephrectomy
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10 , 19 83 , to 5-13 , 19 83 , that (I) (we) last saw the deceased alive on 5-12 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Donald H. Hickey | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-13-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
5-18-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
ASBURY TOWN NECK CEME. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Severna Park A.A. Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
William Reese & Sons Mortuary, P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 16 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conish | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 83 11844 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Ralph Ernest Marcoot | | | | 2b. HOUR
5:00 AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov. 8, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
18 YRS. | |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)
Kansas | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1012 Monroe Street 21403 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | |
| 13a. STATE
MD | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Maurice Marcoot | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mathilda Rhrinhardt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
1944-1960 212-38-6998 | | 17. INFORMANT ADDRESS
Naomi E. Marcoot- same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Carcinoma 4 tons</u>
1850
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Prostate Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 Yrs
6 Yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from <u>June</u> , 19 <u>82</u> , to <u>May 30</u> , 19 <u>83</u> , that (1) (we) lost saw the deceased alive on <u>June 7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Raymond G. Herzinger MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-31-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Raymond G. Herzinger MD | | 22e. ADDRESS
100 Ridgely Ave, Annapolis, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
June 2, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Annapolis A.A. MD | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral Chapel-Annapolis, MD | | 25a. DATE REC'D. BY REGISTRAR
JUN 1 1983 | | 25b. REGISTRAR'S SIGNATURE
John A. Smith | | | |

May 30 1913

Chicago, Illinois

White, N.Y. 8 1913
X
Hans (Hansel)

Hansel's 1012 Avenue Street, New York
X
H.A. Hansel's 1012 Avenue Street, New York

Hansel's 1012 Avenue Street, New York
X
H.A. Hansel's 1012 Avenue Street, New York

Hansel's 1012 Avenue Street, New York
X
H.A. Hansel's 1012 Avenue Street, New York

Hansel's 1012 Avenue Street, New York
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H.A. Hansel's 1012 Avenue Street, New York

Hansel's 1012 Avenue Street, New York
X
H.A. Hansel's 1012 Avenue Street, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card (page 1) and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be called and attended.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 3 1 1 8 4 5
REG. NO. DST | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
DONALD J. MARTIN | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 7, 1983 | | | |
| 2b. HOUR
12:30 M. | | | | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
JUNE 12 1931 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
52 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY, MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
FACTORY | | 12b. KIND OF BUSINESS OR INDUSTRY
DUPONT | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
GLEN BURNIE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOHN A. MARTIN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MAGGIE MAY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
234-46-0660 | | 17. INFORMANT ADDRESS
GARY W. MARTIN 485 MARGARET LN. ARNOLD, MD. 21012 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Liver failure</u>
5712
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Laennec's Cirrhosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>9 years</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 82</u> , to <u>May 7 83</u> , that (I) (we) last saw the deceased alive on <u>May 6 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Bernardino A. Alonso, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/7/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARDINO A. ALONSO, M.D. | | | | 22e. ADDRESS
1406 Crain Highway, s., #102
Glen Burnie, Maryland, 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
May 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
MARTIN FAMILY CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
LESTER RALEIGH W. VA. | |
| 24. FUNERAL DIRECTOR NAME
ROBERT S. BARRANCO | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 12 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Lauer | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove co-bonoppers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|---|--|------------------------------|--|--|--|--------------------------------------|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 3 1 1 8 4 6
REG. NO. | | EDT | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| MACKIE CLEO MARSHALL | | | | MAY | | 22 | | 1983 | | 1132 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS. | | | |
| Male | | Black | | 9 5 02 | | 80 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MD | | USA | | | | ANNE ARUNDEL COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | | | NORTH ARUNDEL HOSPITAL | | | | A.A. Co. Public Works | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. CITY OR TOWN | | | | 13c. INSIDE CITY LIMITS? | | | | 13d. STREET ADDRESS | |
| MD | | | | A.A. | | | | Frederick | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| JOSEPH MARSHALL | | | | M. JONES | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 259-40-6929 | | | | Alice Connors 7833 Levy Ct | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22d. ADDRESS | | | | | | | | | |
| RECEIVED FROM M.D. | | | | 325 HOSPITAL DRIVE, SUITE #104 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 5/29/83 | | Mt Zion Church Pasadena Md | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Marshall R. King | | | | 6/3/83 | | | | MAY 26 1983 John J. Connors | | | | | |

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| DATE | TIME | LOCATION | WIND | TEMP | MOON | SEA |
|----------|-------|----------|-------|-------|-------|-------|
| 17-10-66 | 14:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |
| 17-10-66 | 15:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |
| 17-10-66 | 16:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |
| 17-10-66 | 17:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |
| 17-10-66 | 18:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |
| 17-10-66 | 19:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |
| 17-10-66 | 20:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |
| 17-10-66 | 21:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |
| 17-10-66 | 22:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |
| 17-10-66 | 23:00 | 44-45 | 10-15 | 10-15 | 10-15 | 10-15 |

17-10-66 14:00 44-45 10-15 10-15 10-15 10-15
 17-10-66 15:00 44-45 10-15 10-15 10-15 10-15
 17-10-66 16:00 44-45 10-15 10-15 10-15 10-15
 17-10-66 17:00 44-45 10-15 10-15 10-15 10-15
 17-10-66 18:00 44-45 10-15 10-15 10-15 10-15
 17-10-66 19:00 44-45 10-15 10-15 10-15 10-15
 17-10-66 20:00 44-45 10-15 10-15 10-15 10-15
 17-10-66 21:00 44-45 10-15 10-15 10-15 10-15
 17-10-66 22:00 44-45 10-15 10-15 10-15 10-15
 17-10-66 23:00 44-45 10-15 10-15 10-15 10-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

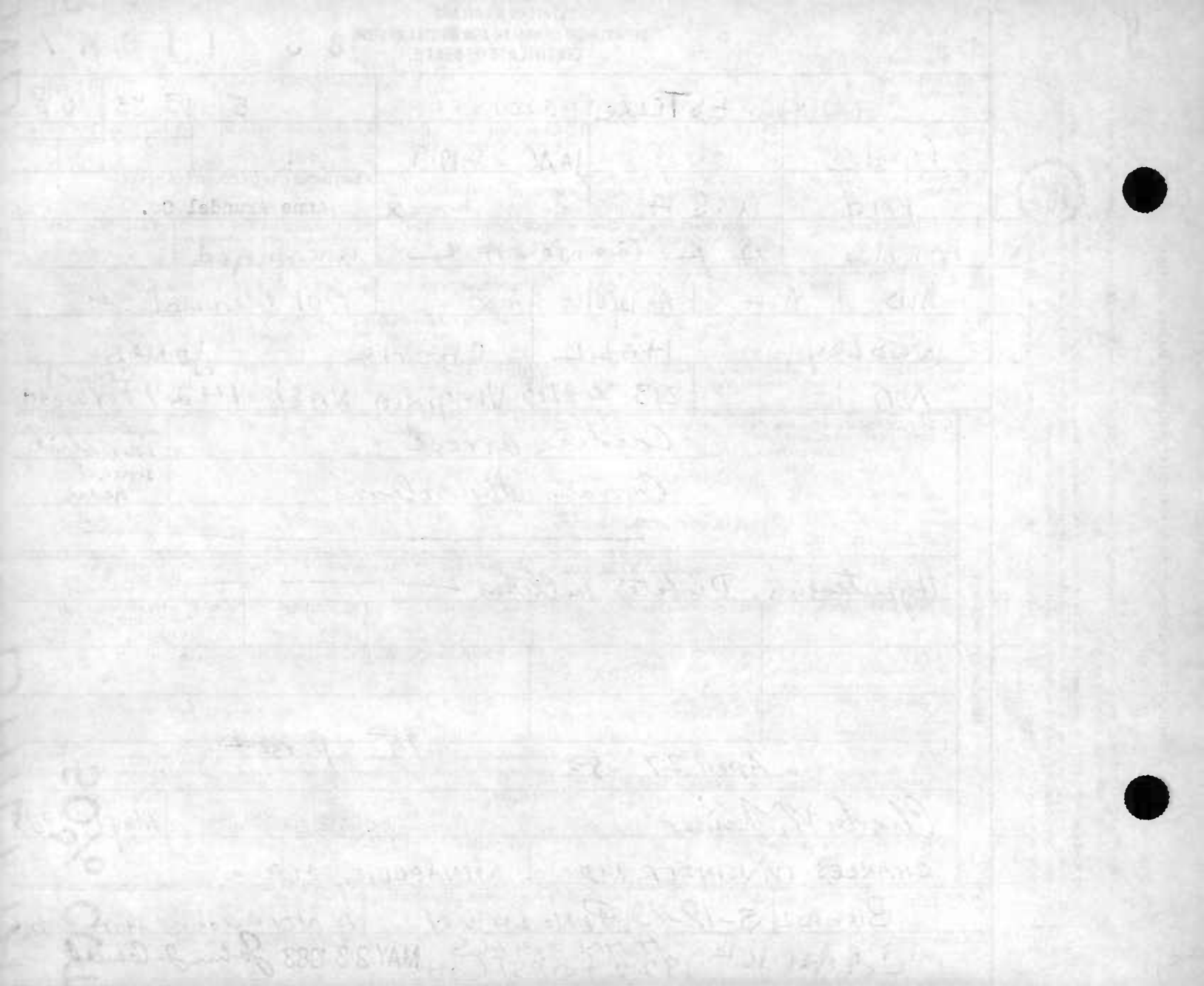
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 7 3 1 1 8 4 7
REG. NO. | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Bertha ESTELLE Mason | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 13 83 | | | | 2b. HOUR
10 ⁴⁰ P. M. | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
JAN 28-1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A. A. General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21401
701 Glenwood St | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wesley HALL | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie JONES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-30-8793 | | 17. INFORMANT
ADDRESS
Virginia Nash 1427 Foxwood Court | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>4140</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Coronary atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u>
<u>Several</u>
<u>years</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Hypertension, Diabetes mellitus</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>75</u> , to <u>present</u> , 19____, that (I) (we) last saw the deceased alive on <u>April 27</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Charles W. Kinzer</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>May 14, 1983</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES W. KINZER MD | | | | 22e. ADDRESS
ANNAPOLIS, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-18-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Pine Lawn | | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE
Annapolis A.A. md | | | | | |
| 24. FUNERAL DIRECTOR
NAME
C.E. Hulse | | | | ADDRESS
ANNAPOLIS
1922 Forest Dr | | 25a. DATE REC'D BY REGISTRAR
MAY 23 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carroll | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Report may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 3 1 1 8 4 8 | | | | |
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
TIMOTHY MCCOCHRAN | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 1 83 | | | 2b. HOUR
2:25 PM | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 17 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
21 08 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 12. CITY OR TOWN OF DEATH
MILLERSVILLE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
728 Cecil Avenue | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 15. KIND OF BUSINESS OR INDUSTRY | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
MILLERSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
728 Cecil Avenue 21108 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CLEVE MCCOCHRAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FRANCIS BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
MAE MCCOCHRAN 728 Cecil Ave. Millersville, Md. 21108 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4340
IMMEDIATE CAUSE (a) Aspiration pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral embolism, RR
DUE TO, OR AS A CONSEQUENCE OF (c) Serious
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Serious | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
83 511 83 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE
A.E. SUBONG, JR. MD PA | | | 22c. DEGREE | | | 22d. DATE SIGNED
5/3/83 | | 22e. ADDRESS
206 CRAIN HOYSW GLEN BURNE | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
5-4-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
PINELAWN MEM. PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis A.A. Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WILLIAM REESE & SONS MORTUARY, P.A. | | | | | 25. DATE RECEIVED BY REGISTRAR
MAY 3 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | |

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Suzanne A. Allard

2000 40 1000

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must show any injury, or other traumatic event, the medical examiner must be notified and cleared by, Dr. Elmer G. Linhardt, DME

Cleared by, Dr. Elmer G. Linhardt, DME

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 4 9
REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Raymond L. McCutchen | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 29, 1983 | | | |
| 3. SEX
Male | | | | 2b. HOUR
12:22 AM | | | |
| 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
December 27, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundle County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundle General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Dairy | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundle | | 13c. CITY OR TOWN
Edgewater | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George McCutchen | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Hanes | | 13e. STREET ADDRESS
205 Arunah Ave. 21037 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- - - - - 578-05-6286 | | 17. INFORMANT
ADDRESS
205 Arunah Ave.
Alise C. McCutchen Edgewater, Maryland 21037 | | | |
| 18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Coronary Artery Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>Diabetes Mellitus</u> <u>Multiple Myeloma</u> | | | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/18/75</u> , to <u>5/29/83</u> , that (I) (we) last saw the deceased alive on <u>3/29/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>5/31/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Vivek C. Vaid, M. D. | | 22e. ADDRESS
Suite 308 20783
7676 New Hampshire Ave. Langley Park, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 31, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Pr. George's, MD | |
| 24. FUNERAL DIRECTOR
NAME
Beall Funeral Home | | 24b. ADDRESS
6000 Annapolis Rd.
Bowie, Maryland 20715 | | 25a. DATE REC'D. BY REGISTRAR
JUN 2 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

CONFIDENTIAL - NO FORN DISSEM

Local Area 1000

10000

Lincoln County, Oregon

1000

1000

1000

1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be called at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 5 0
REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Hazel Snowden McGowan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5-1-83 | | | 2b. HOUR
4:20 AM | | | |
| 3. SEX
F | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 10 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Press Shop | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. NAVY | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1904 F. Cope Land ST 21401 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Oshie Unkn Snowden | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE Unkn Soney | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-16-0378 | | 17. INFORMANT
James Henry McGowan 1904 F. Cope Land | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
5728 IMMEDIATE CAUSE (a) Hepcho renal syndrome
DUE TO, OR AS A CONSEQUENCE OF
(b) Hepatic failure
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-27-83 to 5-1-83, that (I) (we) last saw the deceased alive on 4-30-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
A. Caputo | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-1-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. CAPUTO | | | 22e. ADDRESS
132 Holiday Court ANNAPOLIS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
May 6, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
PINE LAWN ANNAPOLIS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNAPOLIS A.A. MD | | | |
| 24. FUNERAL DIRECTOR
NAME
C. E. Hicks III | | | ADDRESS
1922 Forest Drive | | | 25a. DATE REC'D. BY REGISTRAR
MAY 9 1983 | | | |
| | | | REGISTRAR'S SIGNATURE
John J. Lauer | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 5 1
REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Lillian M McGuire</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>5-13-83</i> | | 2b. HOUR
<i>8:40 P.M.</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>10 30 86</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>96</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>md.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>A.A.CO.</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore P.O.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Hammonds Lane Nursing Home</i> | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>at home</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>md.</i> | | 13b. CITY OR TOWN
<i>BALTIMORE</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<i>1132 Cleveland St #21230</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Harry Gurlock</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>? ? ?</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>-</i> | 17. INFORMANT
ADDRESS
<i>Richard J. McGuire Jr. 21061
1216 Lenox Dr.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>
<i>4292</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>A.S.C.V.D.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>BRONCHOPNEUMONIA, DEGENERATIVE DEMENTIA, OSTEODARTHRITIS.</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/30/1982</i> , to <i>5/13/1983</i> , that (I) (we) last saw the deceased alive on <i>5/13/1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>K. D. Harmasena</i> | | DEGREE
<i>M.D.</i> | | 22c. DATE SIGNED
<i>5/14/1983</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>K. D. HARMASENA</i> | | 22e. ADDRESS
<i>#8, 16th AVENUE, BALTIMORE MD 21225</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>burial</i> | | 23b. DATE
<i>5-17-1983</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>New Cathedral Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Balti. Md.</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>John J. Corwin & Son, Inc. 901</i> | | ADDRESS
<i>Balti. Md. 21223
Hollins St.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAY 17 1983</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>John J. Corwin</i> | | | | | |

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 3 1 1 8 5 2 EDT | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| MABLE Clark | | MCNEIL | | | | | | MAY 19, 1983 | | 0224 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | Black | | Sept. 30, 1916 | | 66 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| South Carolina | | U.S.A. | | | | ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | | | | | Domestic | | Pvt. Family | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | | | | | | | |
| Maryland Baltimore | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Bennie Clark | | | | | | Jannie Harrington | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | | | Mary Clark- 608 N. Gilmore St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <i>synthimise</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic coronary vascular</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>accident</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>sk cerebral vascular</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| | | | | | | | | | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/19</i> 19 <i>83</i> to <i>5/19</i> 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>5/19</i> 19 <i>83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. ADDRESS | | | | 22d. DATE SIGNED | | | |
| <i>Ray Brodie</i> | | MD | | 844 NORTH CAREY STREET | | | | 5/21/83 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS | | | | | | | | | |
| RAY BRODIE, M.D. | | BALTIMORE, MARYLAND 21217 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN | | | |
| Burial | | 5/23/83 | | Mt. Auburn Cem. | | | | Baltimore, City Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | | REGISTRAR'S SIGNATURE | | | |
| <i>Hebert E. Witter</i> | | <i>3035 W. North Ave.</i> | | MAY 23 1983 | | | | <i>John J. Conner</i> | | | |

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| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 3 1 1 8 5 3
REG. NO. | | EDT | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FRANK E. MEISNER | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 3, 1983 | | 2b. HOUR P M
12:20 P M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
10 15 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SALES | | 12b. KIND OF BUSINESS OR INDUSTRY
STORE OWNER | |
| 13a. STATE
MD. | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
CROFTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
UNKNOWN Conrad Meisner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
JENNY UNKNOWN Phillips | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
102-09-5963 | |
| 17. INFORMANT ADDRESS
EVELYN MEISNER 1560 Bandury Ct. Crofton, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
2080
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>acute leukemia</u>
(c) <u>aplastic myeloid metaplasia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Severe dementia consistent with Alzheimer's type</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4-23</u> 19 <u>83</u> , to <u>5-3</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5-2</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Paul S. Rhodes</u> | | | | DEGREE
M.D. | | 22c. DATE SIGNED
5-3-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL S. RHODES, M.D. | | | | 22e. ADDRESS
1667 Crofton Center
Crofton, Md. 21114 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
5/4/83 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR (M) REGISTRAR'S SIGNATURE
MAY 9 1983 <u>John J. Lohr</u> | |



20% COTTON FIBER

DAVID J. M.



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BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 5 4
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Frances G. Meuse | | 2a. DATE OF DEATH MONTH DAY YEAR
6 9 83 | | 2b. HOUR
4:15 AM | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
6-20-00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
82 YRS | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE
MD | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
Edgewater | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph Daley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Julia Campbell | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
218-80-8243 | | 17. INFORMANT ADDRESS
William E. Meuse, Jr. 234 Pearl Street Springfield MA 01105 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral aneurysm
4479
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Stroke
(c) mesenteric artery (disease)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Stephen B. Hiltabidle MD | | DEGREE
MD | | 22c. DATE SIGNED
May 9 '83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen B. Hiltabidle MD | | 22e. ADDRESS
801 Melvin Ave, Annapolis, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 11, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine | |
| 23d. LOCATION CITY OR TOWN
Baltimore | | COUNTY
MD | | STATE | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral Chapel - Annapolis, MD | | 25a. DATE REC'D. BY REGISTRAR
MAY 12 1983 | | | |
| | | 25b. REGISTRAR'S SIGNATURE
John J. Givens | | | |



Female White

NY USA X

100 49 1960s X

Joseph

01

X



2060 001

Stephen & H. H. Bigelow & H. H. Bigelow

1960 4/11/63 1963 4/11/63

1960 4/11/63 1963 4/11/63

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 3 | | 1 | | 1 | | 8 | | 5 | | 5 | |
|---|--|---------|--|--|--|------------------------------------|--|---|--|--|--|--------------------------------------|--|---|---|---------------------|--|---|--|--|--|--|--|----------|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | | 2a. DATE KNOWN OF ESTI-
MATED | | MONTH DAY YEAR | | 2b. HOUR | | M | | M | | | |
| WILLIAM W. MEYER | | | | | | | | | | | | | | | | | | | | 5/7/1983 | | 19 | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 7c. DATE
PRONOUNCED
DEAD | | MONTH DAY YEAR | | 2d. HOUR | | M | | M | | | | | | | | | | | |
| Male | | white | | 5/7/1905 | | 78 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | U.S.A. | | | | | | | | Anne Arundel County, MD | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | | | |
| Glen Burnie | | | | 8189 New Cut Road (21061) | | | | | | | | | | salesman | | | | Retailing | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | |
| Md. | | A. A. | | Glen Burnie | | | | | | | | 8189 New Cut Road 21061 | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | | | |
| Louis Meyer | | | | | | | | | | Hattie Luedke | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | 220 09 5701A | | George H. Meyer (same as 13e) | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| 4360 IMMEDIATE CAUSE (a) MALNUTRITION | | | | | | | | | | | | | | | | | | 3 mon. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Cerebrovascular Accident | | | | | | | | | | | | | | | | | | 1 y n. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | | | |
| Richard E. Cook | | | | | | | | | | M.D. Sub. Dep. | | | | | | | | | | 5/9/83 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| Richard E. Cook | | | | | | | | | | 113 Cathedral St. Annap. Md. | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | | | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Burial | | | | | | | | | | 5/10/83 | | Cedar Hill Cemetery | | | | | | | | | | Brooklyn Pk., A.A.Co., Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| George J. Gonce, 4001 Ritchie Hg., Baltimore, Md. | | | | | | | | | | MAY 11 1983 | | | | | | | | | | John J. Gonce | | | | | | | | | | | |



1911

1912

Abraham Lincoln
Camp, near the
River

1913

X

1914

1915 (to the end of the year)

Richard E. Cook
Richard E. Cook

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 5 6
REG. NO. DST | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | |
| TRECIA MAY MURPHY | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| MAY 30, 1983 | | | | 2b. HOUR AM | | | |
| 11:10 M | | | | 3. SEX | | | |
| Female | | | | 4. RACE | | | |
| White | | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | |
| 7 7 1910 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| 72 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | | |
| IF UNDER 24 HRS. HOURS MIN. | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| ANNE ARUNDEL COUNTY MD. | | | | 10. CITY OR TOWN OF DEATH | | | |
| GLEN BURNIE | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | |
| NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE | | | | 13b. COUNTY | | | |
| Md. | | | | A.A. | | | |
| 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| Brooklyn | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET ADDRESS | | | | 13f. STREET ADDRESS | | | |
| 5604 Patrick Henry Dr. (21225) | | | | 14. FATHER'S NAME FIRST MIDDLE LAST | | | |
| Edward Thompson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Nora W. Willoughby | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| No | | | | 16b. SOCIAL SECURITY NO. | | | |
| 217-20-1347 | | | | 17. INFORMANT ADDRESS | | | |
| Betty Dull 108 Buckingham Ave. (21061) | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> | | | | | | | |
| 4/00 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | |
| CHARLES J. WU, M.D. | | | | May 30, 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 7845 OAKWOOD ROAD, #204 | | | | GLEN BURNIE, MD. 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | |
| Burial | | | | 6/2/83 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Meadowridge Mem. | | | | Howard Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| George J. Gonce F.H. 4001 Ritchie Hy. | | | | JUN 01 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

BP

| | | | | |
|----|---------------|----------|------|----------------|
| 10 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 11 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 12 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 13 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 14 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 15 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 16 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 17 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 18 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 19 | 217-22-1-1075 | Thompson | None | W. J. Thompson |
| 20 | 217-22-1-1075 | Thompson | None | W. J. Thompson |

W. J. Thompson
217-22-1-1075
Thompson
None
W. J. Thompson

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11857 | |
|--|------------------|---|--|---|------------------|--|----------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) William Napier | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 5-19-83 | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH (MONTH DAY YEAR) 2 16 12 | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD 5-19-83 | 7d. HOUR 1009 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel | | | | MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stationary Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Boilers | | | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7619 Bush Ave 21122 | | | |
| 14. FATHER'S NAME (TYPE OR PRINT) William Napier Sr. | | | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Rena Buckingham | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-09-9462 | | 17. INFORMANT (NAME AND ADDRESS) William C. Napier 14017 Matthews Dr. Woodbridge Va. 22191 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4960 IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) COPD
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE George E. Lutz | | | | TITLE (SPECIFY) Dep. | | | | DATE SIGNED 5-19-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) G. Linhardt | | | | ADDRESS 312 Washington St | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-23-83 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest | | 23d. LOCATION CITY OR TOWN Annapolis COUNTY A.A. STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME I.A. Hardesty ADDRESS Annapolis Md. 21401 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carish | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | 8 3 1 1 8 5 8
REG. NO. EDT | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST
ESKIL M. OHLSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 5, 1983 | | 2b. HOUR
6:25 A.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JUNE 27, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
PHOTOGRAPHER | | 12b. KIND OF BUSINESS OR INDUSTRY
SELF EMPLOYED | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE CITY OF DEATH
MARYLAND ANNE ARUNDEL SEVERNA PARK | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
319 THOMAS ROAD
LOWER MAGOTHY BEACH 21146 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
EMIL M. OLSON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE
EBBA M. JACKSON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
225-22-1529 | | 17. INFORMANT
DOROTHY S. OHLSON | | | ADDRESS
P.O. BOX 66
THOMAS AVENUE
SEVERNA PARK | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Fibrosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Radiation Therapy</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Small Cell Lung Cancer</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
1629
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
P. Konits | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/5/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P. Konits | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
5/5/83 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 11 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | |

BP



MALE

WHITE

JUNE 27, 1907

75

ILLINOIS

U.S.A.

ANNE ARUNDEL COUNTY

GLYN BURNIE

NORTH ARUNDEL HOSPITAL

PHOTOGRAPHER SELF EMPLOYED

MARYLAND ANNE ARUNDEL SEVERN PARK

X

LOWER MAGDOY BEACH

EMIL

M.

CLSON

EBBA

M.

JACKSON

NO

225-22-1550 DOROTHY G. OLSON

710 THOMAS AVENUE
P.O. BOX 68
SEVERN PARK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR
STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 5 9
REG. NO. d8t | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
URIAS | | | | FIRST
OLIVER | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 25, 1983 | | | | 2b. HOUR
2:45P M | | | |
| 3. SEX
Male | | | | 4. RACE
Black | | | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 / 1916 | | | | 6. AGE (IN YEARS (LAST BIRTHDAY))
MONTHS DAYS HOURS MIN.
67 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(GIVE WORK, IF MOST OF WORKING LIFE)
Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Concrete Pipe | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
md | | | | 13b. COUNTY
AA | | | | 13c. CITY OR TOWN
Glen Burnie | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Chester | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Blanche Lambill | | | | 13e. STREET ADDRESS
7885 Jordan Ct 21061 | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest
1850
DUE TO, OR AS A CONSEQUENCE OF
(b) Paraplegia Legs in
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Carcinoma of Prostate | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-20 , 19 83 , to 5-25 , 19 83 , that (I) (we) last saw the deceased alive on 5-25 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Chackumkal | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5-26-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHACKUMKAL V. CYRIAC, M.D. | | | | 22e. ADDRESS
14 WELLHAM AVE.
GLEN BURNIE, MD. 21061 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
Burial | | | | 23b. DATE
5/28/83 | | | | 23c. NAME OF CEMETERY OR CREMATORY
St Rest | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Banner AA md | | | |
| 24. FUNERAL DIRECTOR
Turnell | | | | ADDRESS
Balden Ball, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 26 1983 | | | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

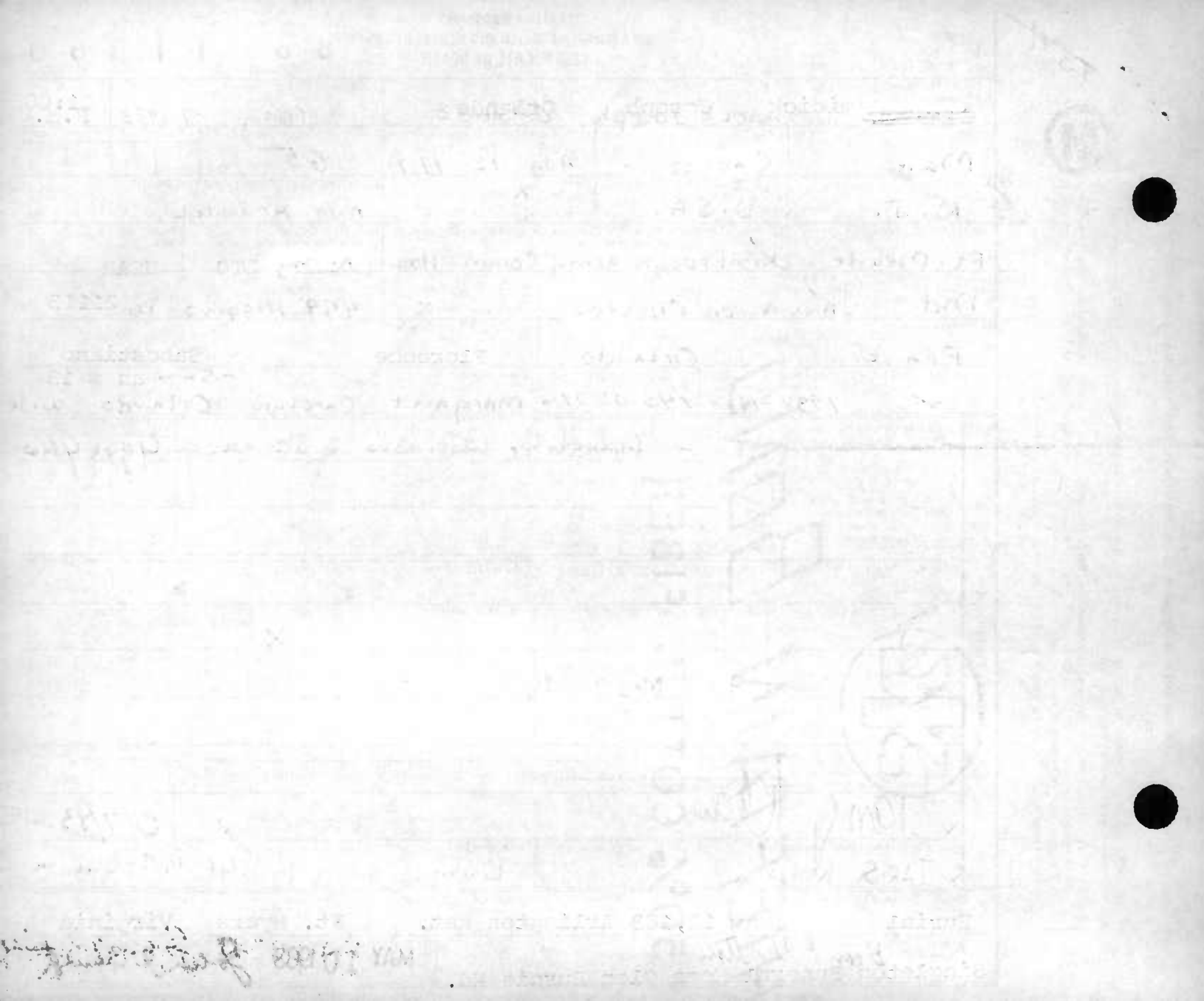
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8311860

REG. NO.

| | | | | | |
|--|---|---|---|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | P.M. | |
| Dominick Joseph Orlando | | May 7, 1983 | | 21:00 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Male | White | MONTH DAY YEAR | 65 YRS. | Anx Arundel, MD. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| N. J. | U. S. A. | | Anx Arundel, MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Ft. Meade | Kimbrough Army Comm. Hosp | Retired LTC | USAR | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| md. | ANN Arundel | ODenton | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 499 Higgins Dr. 21113 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. ADDRESS - Same as # 13 | | | |
| Frank | Florence | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| Yes | 1938-1968 | Margaret Carolyn Orlando wife | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Melastatic Carcinoma of Stomach.</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs 4 mo |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
9 P.M. May 7 1983 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) _____ the body after death. | | | | | |
| 22a. SIGNATURE
x TARIQ KHAN | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/7/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
x TARIQ KHAN | | 22e. ADDRESS
Kimbrough Army Hospital. Ft Meade in | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Burial | May 12, 1983 | Arlington Nat. | Ft. Myers Virginia | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Dean P. Charlton | | MAY 10 1983 | | John P. Linnell | |
| 26. ADDRESS
Singleton Funeral Home Glen Burnie Md. | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 202-343-1234.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 3 1 1 8 6 1
REG. NO. | | | | |
|---|--|---|--|---|---|--|---|---|-------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) SALLY UNDERWOOD O'ROURKE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-28-83 | | | | 2b. HOUR 8:53 PM |
| 3. SEX Female | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 11-24-35 | | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT THROUGH FACILITY, GIVE STREET ADDRESS) HAGEN Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD. | | 13a. CITY OR TOWN Annapolis | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS 2644 GREENBRIAR LANE #1403 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RICHARD LASKEY UNDERWOOD | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY J. DOYLE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 579521047 | | 17. INFORMANT FREDERICK O'ROURKE | | ADDRESS # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4373 IMMEDIATE CAUSE (a) Cerebral Aneurysm
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION 5/27/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory INSUFFICIENCY | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 24, 1983 to MAY 28, 1983 , that (I) (we) lost saw the deceased alive on MAY 28, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Jack Kueshner | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/28/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Kueshner | | 22e. ADDRESS 20 Ridgely Annapolis, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 6/1/83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Southand PG. MD. | | | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel | | ADDRESS Annapolis, MD | | 25. DATE REC'D. BY REGISTRAR MAY 31 1983 | | 26. REGISTRAR'S SIGNATURE John J. Gainer | | | |

continued water disposal

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carboncopiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 6 2
REG. NO.

| | | | | | | |
|--|------------------|--|--|---|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Joshua Paddy | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5/14/1983 | | 2b. HOUR
6 ²⁵ P. M. | |
| 3 SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
12 32 88 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9a. CITY OR TOWN OF DEATH
Annapolis | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | |
| 10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Anne Arundel General Hospital | | 12a. USUAL OCCUPATION (IF MOST OF WORKING LIFE)
Farmer | | |
| 13a. STATE
Md | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Lothian | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Paddy | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Catterton | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
217-38-7200 | | 17. INFORMANT
ADDRESS
Carolyn Wells Lothian Md. 20711 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Leukemia</u>
2080 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>one month</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>No operation</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<u>No injury</u> | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/14/83</u> 19 <u>66</u> , to <u>5/14</u> 19 <u>83</u> , that (I) (we) lost above, (I) (we) (did) not view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | |
| 22b. SIGNATURE
<u>Charles H. Wirth MD</u> DEGREE | | | | 22c. DATE SIGNED
<u>5/16/83</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles H. Wirth MD | | | | 22e. ADDRESS
Lothian Md | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-17-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lothian A.A. Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
T.A. Hardesty Annapolis, Md. 21401 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAY 18 1983 | | | | 25b. REGISTRAR'S SIGNATURE
<u>J. J. Conner</u> | | |

BP



James M. White
12-12-19

James M. White

James M. White

James M. White

James M. White

James M. White
12-12-19

James M. White
12-12-19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 3 1 1 8 6 3

| | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lauretta | | | FIRST MIDDLE LAST
Page | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 28 83 | | | 2b. HOUR
12 N.M. | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH MONTH DAY YEAR
May 29 1904 | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
78 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSP. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY
HOUSEHOLD | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
A.A. | | | 13c. CITY OR TOWN
DAVIDSONVILLE | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
PAUL LEY | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CLARA GIEHLER | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
578-28-2024 | | |
| 17. INFORMANT ADDRESS
JOSEPH E. BLEVINS DAVIDSONVILLE, MD | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4100
DUE TO, OR AS A CONSEQUENCE OF (b) Probable Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.
Papet's Disease, Alzheimer's Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-11 , 19 83 , to 5-28 , 19 83 , that (I) (we) last saw the deceased alive on 5-27-83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
ERROL A - Phillip | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
5/29/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERROL A - Phillip | | | 22e. ADDRESS
20 Ridgely Ave, Anne md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
5/31/83 | | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE MD | | |
| 24. FUNERAL DIRECTOR
HARDESTY FUNERAL HOME | | | | | | ADDRESS
ANNAPOLIS, MD | | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1983 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
John J. Conish | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 6 4
REG. NO. EDT

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LLOYD K PARKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 02, 1983 | | 2b. HOUR
0544 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 17, 1914 | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY A.A. 13c. CITY OR TOWN Glen Burnie | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
6656 Roberts Ct. 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Parker | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kattie Brown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
218-03-4027 | 17. INFORMANT ADDRESS
Marion C. Parker 7900 Bennesch Cir. Apt. 817 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4280 Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) CHF.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/2, 1983, to 5/2, 1983, that (I) (we) lost saw the deceased alive on 5/2, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Hamid Towhidian, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. HAMID TOWHIDIAN | | 22e. ADDRESS
3236 MOUNTAIN ROAD PASADENA, MARYLAND 21122 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
6 Apr. 83 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Howard MD | |
| 24. FUNERAL DIRECTOR
NAME
James S. Kirkley F.H. Glen Burnie MD. | | 25a. DATE REC'D. BY REGISTRAR
MAY 5 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | |

Items #8a-22a Film G581 7/20/83 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11865

FOR
 1- STATE
 REGISTRAR

| | | | | | | | | | | | |
|--|---------|------------------------------|---------|--|-------------------------|---|--|---|----------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| Richard Kiel Parker | | | | X MONTH DAY YEAR | | | | 5 17 19 83 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 24 HRS. | 8. DATE PRONOUNCED DEAD | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. HOUR | | |
| Male | White | Feb 17, 1953 | 30 YRS. | MONTHS DAYS HOURS MIN. | 5 17 19 83 | Anne Arundel County | | | 10:50 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. HOUR | | |
| Baltimore, MD | | USA | | | | Anne Arundel County | | | MD | | |
| 11. CITY OR TOWN OF DEATH | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Annapolis | | | | Anne Arundel General Hosp. | | | | Car Painter | | | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Anne Arundel | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21061 7900 Benesch Circle, Apt. 759 | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Lloyd K. Parker | | | | | | Marion C. Kaler | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| No | | | | 217-82-6425 | | | | Joan M. Parker, Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | |
| 4292 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| Fatty Liver | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | |
| | | | | | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| Dennis F. Smyth, M.D. | | | | Assistant | | | | 5-18-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | | 21 May 1983 | | Meadowridge Mem. Park | | Elkridge Howard MD | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | |
| NAME ADDRESS | | | | | | REGISTRAR'S SIGNATURE | | | | | |
| James S. Kirkley, Glen Burnie, MD | | | | | | MAY 27 1983 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED
JAN 10 1941

NOV 10 1940

NOV 10 1940

NOV 10 1940



MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 6 6
REG. NO. | | | | |
|---|--|---|--|---|--|---|--|-------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Charlotte E. Pattison | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 13, 1983 | | | | 2b. HOUR 9:30a M |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR November 16, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oregon | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant-Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY State | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. | | 13b. COUNTY AA | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George T. Parker | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Paul | | 13e. STREET ADDRESS 522 Arundel Avenue, 21061 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-18-0570 | | 17. INFORMANT ADDRESS Paul Pattison, 104 Truckhouse Rd., Severna Park | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| 2028 IMMEDIATE CAUSE (a) hypertension | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 5/13/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE S P Watkins | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/13/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S P WATKINS | | 22e. ADDRESS Cathedral Street, Annapolis, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 18 May 83 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA Md. | | |
| 24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md. | | | | 25a. DATE REC'D BY REGISTRAR MAY 18 1983 | | 25b. REGISTRAR'S SIGNATURE J. L. King | | |

②

2082 COTTON EMB

MADE IN U.S.A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 1 1 8 6 7
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WATERS Stevenson Peake | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 27 1983 | | 2b. HOUR M |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR MAR 29 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West River Md. USA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH 7 Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH West River | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chalk Pt. Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Tobacco |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. | 13b. COUNTY A.A. | 13c. CITY OR TOWN West River | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS Chalk Pt. Rd. 20778 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Millard Peake | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Cole | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-12-9302 | 17. INFORMANT ADDRESS Ruth E. Peake Chalk Pt. Rd. West River Md. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

7991

IMMEDIATE CAUSE (a) **Respiratory Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **multiple**

| | | | |
|---|---|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (and) did not know the body after death. | | | |
| 22b. SIGNATURE [Signature] | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jacob T. Tetzelschman | | 22e. ADDRESS 139 Old Solomons Island Rd Annapolis Md | |

| | | | |
|---|--------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5/31/83 | 23c. NAME OF CEMETERY OR CREMATORY Woodfield Cemetery Galesville, Md. | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ann. Md. Hardesty Funeral Home 12 Ridgely Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 31 1983 | 25b. REGISTRAR'S SIGNATURE [Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 6 8
REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | |
|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Russell B Phillips | | 2a. DATE OF DEATH MONTH DAY YEAR
May 17, 1983 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR
June 27 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 1/2 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Silver Hill Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer Wah. | 12b. KIND OF BUSINESS OR INDUSTRY
Gas Light |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md. | | 13b. COUNTY
A.A. Co. | 13c. CITY OR TOWN
Churchton | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charlie Franklin Phillips | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Edith Burton | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 577-09-7137 | | 17. INFORMANT ADDRESS
Marilyn Phillips same as 13 E. |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Arrest / Cardiogenic Shock | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute Arrhythmia | | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease | | years |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Chronic Obstructive Lung Disease / Diabetes Mellitus II

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 8/19 , 19 77 , to May 17 , 19 83 , that (a) (we) lost
saw the deceased alive on May 17 , 19 83 , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Gerald P. Sterner | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
May 17, 1983 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gerald Sterner | | 22e. ADDRESS
Owings, Maryland | |

| | | | |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/19/83 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Honesty Funeral Home 12 Kingly Ave Annapolis | | 25a. DATE REC'D. BY REGISTRAR
MAY 18 1983 | 25b. REGISTRAR'S SIGNATURE
John J. Conish |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.



1952-53

1953-54

1954-55

1955-56

1956-57

1957-58

1958-59

1959-60

1960-61

1961-62

1962-63

1963-64

1964-65

1965-66

1966-67

1967-68

1968-69

1969-70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 6 9

FOR
1 - STATE
REGISTRAR

REG. NO.

EDT

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
INEZ PITTS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 16, 1983 | | 2b. HOUR
809 PM |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
10 14 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | | | 13b. COUNTY
A.A.CO. | 13c. CITY OR TOWN
Severn | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Pitts | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amelia Turner | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-12-6034 | | 17. INFORMANT
ADDRESS
VICTORIA B. HUNDOLL 5/A | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). ACUTE RESPIRATORY OBSTRUCTION,
4850 SECONDARY TO HEMOPTYSIS.
DUE TO, OR AS A CONSEQUENCE OF
(b). ACUTE BRONCHOPNEUMONIA WITH ABSCESS
CAVITY.
DUE TO, OR AS A CONSEQUENCE OF
(c).

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16/83 to 5/16/83, that (I) (we) lost
saw the deceased alive on 5/16/83, and that in (my) (our) opinion death occurred on the day and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
ANASTACIO E. SUBONG, M.D. | DEGREE | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS
206 CRAIN HIGHWAY S. W.
GLEN BURNIE, MARYLAND 21061 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
5-21-83 | 23c. NAME OF CEMETERY OR CREMATORY
HALL'S Church Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE A.A.CO Md |
| 24. FUNERAL DIRECTOR
NAME
BROWN-THOMPSON F.H. | ADDRESS
1913 W. B. H. ST. | 25a. DATE REC'D. BY REGISTRAR
MAY 19 1983 | 25b. REGISTRAR'S SIGNATURE
John J. Connel |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 3 1 1 8 7 0
REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR Daniel A. Poffenberger | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
[TYPE OR PRINT] Daniel A Poffenberger | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 5 09 83 | | 2b. HOUR
458 PM | |
| 3 SEX
Male | | 4 RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR 09 07 15 | | 6. AGE [IN YEARS (LAST BIRTHDAY)]
67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Pasadena | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
[IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS]
7799 Edgewood Ave. | | | | 12a. USUAL OCCUPATION
[TYPE OF WORK FOR MOST OF WORKING LIFE]
Clergy | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY A.A. 13c. CITY OR TOWN Pasadena | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
7799 Edgewood Ave. (21122) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel L. Poffenberger | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah A. Lettich | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
179-09-3933 | | 17. INFORMANT ADDRESS
Gertrude Poffenberger (same as 13e) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Ca colon
DUE TO, OR AS A CONSEQUENCE OF
(c) Adenocarcinoma Colon | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
6 months
3 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 4, 19 83 to 5/19 83 , that (I) (we) lost
saw the deceased alive on 5/16 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Constantine J Padussis | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/10/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Constantine J Padussis | | | | 22e. ADDRESS
7310 Ritchie Hwy Glen Burnie | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
5/12/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. | |
| 24. FUNERAL DIRECTOR
NAME Balto., Md. 21225
George J. Gonce F.H. | | | | ADDRESS
4001 Ritchie Hgwy. | | 25a. DATE REC'D. BY REGISTRAR
MAY 11 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP



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Environ Biol Fish (2015) 98:1131–1140

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1995-1996

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151

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1004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 7 1
REG. NO. | | | | | |
|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
HERMANN J. Pospisil | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 19 83 | | | | 2b. HOUR
A.M. | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR
7 19 1927 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.
55 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
COLOGNE W. GERMANY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10 CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A.H. GEN. Hospt. | | 12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE)
MECHANIC MAINTENANCE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD. | | | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
EDGEWATER | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
HERMANN E Pospisil | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
KATHARIA BRUCKNER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
112-54-5754 | | 17. INFORMANT ADDRESS
ELSIE N. Pospisil #13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Tumor - Glioblastoma Multiforme
1919
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert M. Greenfield | | | | | | DEGREE | | 22c. DATE SIGNED
5/19/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT GREENFIELD | | | | | | 22e. ADDRESS
139 Old Solomon's Isl. Rd. Edgewater Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
5/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY
F. HINCHMAN | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BRENTWOOD P.G. MD. | | |
| 24 FUNERAL DIRECTOR NAME
TAYLOR FUNERAL CHAPEL | | | | | | ADDRESS
ANNAPOLIS, MD. | | 25. DATE REC'D. BY REGISTRAR (5) REGISTRAR'S SIGNATURE
MAY 24 1983 John J. Connel | |

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(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item #5&6 Film G580 6/7/83 re

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 7 2

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Anthony J. Postellon | | 2a. DATE OF DEATH
MONTH DAY YEAR
5-24-83 | | 2b. HOUR
8:22 M | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
10 8 1906 | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
76 77 YRS. | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH
Cummas | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Civil Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Pennsylvania | | 13b. CITY OR TOWN
West Mifflin | 13c. STREET ADDRESS
4817 Brierly Drive | | 15122 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Postellon | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW 11 206-05-8758 | | 17. INFORMANT
ADDRESS
4817 Brierly Drive West Mifflin, Pa. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
+372 IMMEDIATE CAUSE (a) Hypertensive Encephalopathy
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) COPD
DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5-24 , 19 83 , to 5-24 , 19 83 , that (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5-24 , 19 83 , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If "we" (and) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. Lichtenstein | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-25-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Lichtenstein | | 22e. ADDRESS
20 Ridley Ave ANNAPOLIS, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-28-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Jefferson Memorial Park Pleasant Hills | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Allegheny, Pa. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Marzullo Funeral Service | | ADDRESS
Reisterstown, Md. | | 25a. DATE SPEC'D BY REGISTRAR
MAY 27 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Canfield | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 4 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE FILES OF THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3

REG. NO. 1 1 8 7 3

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|--------------------------|--|--------------------------|--|--------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
John | | MIDDLE
Thomas | | LAST
Pullin | | 2b. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH
5 | | DAY
7 | | YEAR
1983 | | 2b. HOUR
3:00 | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH
6 | | DAY
25 | | YEAR
1999 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YR.
MONTHS | | IF UNDER 24 HRS.
DAYS | | HOURS | | MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED
WIDOWED | | NEVER MARRIED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel | | | | | | | | | |
| 11. CITY OR TOWN OF DEATH
Deale | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5921 Deale Beach Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Deale | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
5921 Deale Beach Road | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST
UNKNOWN | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME
FIRST
UNKNOWN | | MIDDLE | | LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
718 14 9981 | | 17. INFORMANT
Dennis McCarthy | | ADDRESS
McLeod Va | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
(c) | | DUE TO, OR AS A CONSEQUENCE OF | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 min. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Richard E. Cook | | TITLE (SPECIFY)
Sub. Dep. | | MEDICAL EXAMINER | | DATE SIGNED
5/7/83 | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Richard E. Cook | | ADDRESS
113 Cathedral St., Annap., Md. 21401 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-10-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln | | 23d. LOCATION
CITY OR TOWN
Brentwood | | COUNTY
PG | | STATE
Md | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hardisty Felt | | ADDRESS
12 Ridgely Ave Annapolis Md | | 25a. DATE REC'D. BY REGISTRAR
MAY 13 1983 | | REGISTRAR'S SIGNATURE
John J. Gush | | | | | | | | | | | | | |



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Handwritten text: *Handwritten text, possibly a signature or date, is visible but illegible.*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 1 8 7 4 |
|--|----------------------|---|---|---|---|---|--|--|--|--------------------|
| 1- STATE REGISTRAR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
WILLIAM NMN RICHARDSON | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
5/26/83 | | 2b. HOUR MIN
9 50 | | |
| 3 SEX
Male | 4 RACE
Am. Indian | 5. DATE OF BIRTH MONTH DAY YEAR
7/17/23 | 6. AGE (IN YEARS) LAST BIRTHDAY
59 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD
5/26/83 | | 7d. HOUR MIN
9 50 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Florida | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BROOKLYN | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8 Wallace Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto Parts | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY ANNE ARUNDEL 13c. CITY OR TOWN BROOKLYN | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
8 WALLACE AVE. (21225) | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unknown | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
Korean | | 17. INFORMANT ADDRESS
Mary Ellen Richardson (same as 13e) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4960 IMMEDIATE CAUSE (a) CARDIAC arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic CVD
DUE TO, OR AS A CONSEQUENCE OF
(c) COPD
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
SUDDEN | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | |
| ACTUAL SIGNATURE
George E. Linhardt, Jr., M.D. | | | TITLE (SPECIFY)
Sub. Dep. MEDICAL EXAMINER | | | DATE SIGNED
5/26/83 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
George E. Linhardt, Jr., M.D. | | | ADDRESS
312 Washington St., Annapolis, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
5/31/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Vet's. Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Crownsville Md. | | |
| 24. FUNERAL DIRECTOR NAME
George J. Gonce F.H. | | | | | | ADDRESS
4001 Ritchie Hy. | | 25a. DATE REC'D. BY REGISTRAR
JUN 01 1983 | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Gance | | | | | | | | | | |

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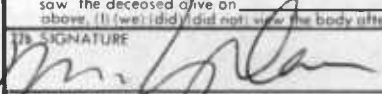

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR SUE PENNINGTON RIFE | | | | | 8 3 1 1 8 7 5
REG. NO. EDT | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) SUE PENNINGT RIFE | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 16, 1983 | | | 2b. HOUR
530 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
4/8/1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
? | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
LEGAL | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
SEVERNA PARK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
216 OLD COUNTY ROAD 21146 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN PENNINGTON | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217.01.9852 | | 17. INFORMANT ADDRESS
JOHN M. JONES SAME AS 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Acute Renal Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)
Hypertension & Vagotomy in Perforated Ulcer | | | | | | | | | |
| 19a. DATE OF OPERATION
3/11/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Perforated Duodenal Ulcer | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
3/11/83 | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
7845 OAKWOOD ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061 | | 22c. DATE SIGNED
5/17/83 | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from above, (I) (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E. Gorbaty MD | | 22c. ADDRESS
7845 OAKWOOD ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELLIOTT GORBATY, M.D. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
5/18/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 6 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 1 1 8 7 6
REG. NO. EDTFOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CATHERINE MARY ELIZABETH RITHMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 21, 1983 | | 2b. HOUR
655 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 28, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | 8b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House wife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
Maryland | | | 13b. COUNTY
Arundel | 13c. CITY OR TOWN
Glen Burnie | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Faller | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Keen | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT (Daughter) ADDRESS
124 Martha Rd.
Mrs. Rosemary L. Hughes Glen Burnie, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u>
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
 | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARC A. KAPLAN, M.D. | | 22e. ADDRESS
7845 OAKWOOD ROAD SUITE 200
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
May 25, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat. Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ft. Myer Virginia | |
| 24. FUNERAL DIRECTOR
NAME
R. H. Hopkins
Singleton Funeral Home, Glen Burnie, Md. | | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1983 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

CHARLES M. RICHARDSON MAY 21 1963

AND ANNE COUNTY

CLINTON COUNTY

Handwritten signature

CLINTON COUNTY 1601
2845 DAWOOD ROAD SUITE 200

WILLIAM A. JARVIS, M.D.

FILE

20%

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1st, 2nd, and 3rd pages, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY ROBINSON | | | | | 26. DATE OF DEATH
MONTH DAY YEAR
5/3/83 | | 26. HOUR
2:15 P.M. | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 21, 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MD. Manor Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
A.A. Co | | 13c. CITY OR TOWN
Glen Burnie | | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET ADDRESS
(21061)
111 Second Avenue, S.W. | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lewis | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Prudence Surran | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT (Son) ADDRESS
407 Delmar Ave.
Mr. William L. Robinson/ 21061 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
1749 IMMEDIATE CAUSE (a) BREAST CANCER METASTASIS TO PERITONEUM
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-27, 1983 to 5-3, 1983 , that (I) (we) lost saw the deceased alive on 4-30, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
DR. PETER RHEINSTEIN | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
5-3-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. PETER RHEINSTEIN | | | | | 22e. ADDRESS
621 HOLLY RIDGE RD, SEV PK 21146 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6 May 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Pk. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD. | | | |
| 24. FUNERAL DIRECTOR
NAME R. H. Hopkins ADDRESS Glen Burnie, MD. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 6 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Smith | | |

BP



Handwritten text, mostly illegible due to blurriness and bleed-through. Visible fragments include:

- Top left: "11/11/11"
- Top center: "11/11/11"
- Top right: "11/11/11"
- Middle left: "11/11/11"
- Middle center: "11/11/11"
- Middle right: "11/11/11"
- Bottom left: "11/11/11"
- Bottom center: "11/11/11"
- Bottom right: "11/11/11"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8311878 | EDT 8 |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ERMA I ROLES | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 25, 1983 | | 2b. HOUR
1000A M |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR
NOVEMBER 19, 1996 | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | | |
| 10. CITY OR TOWN OF DEATH
PASADENA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8 ALTONA AVE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | 12b. KIND OF BUSINESS OR INDUSTRY
BAKERY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY ANNE ARUNDEL 13c. CITY OR TOWN PASADENA | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
104 PASADENA RD. 21122 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
WILLIAM — WATTS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LYDIA — STINCHCOMB | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
— | | 17. INFORMANT ADDRESS
ETHEL WEBSTER (SAME AS 13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1749 IMMEDIATE CAUSE (a) METASTASIS CARCINOMA OF RIGHT BREAST
DUE TO, OR AS A CONSEQUENCE OF (b) —
DUE TO, OR AS A CONSEQUENCE OF (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION
1/10/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
poor | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25, 1983, to 5/26, 1983, that (I) (we) last saw the deceased alive on 5/25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Paul J. Chang MD | | DEGREE
MD | | 22c. DATE SIGNED
5/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL J. CHANG, M.D. | | 22e. ADDRESS
801 CRAIN HIGHWAY S.E. GLEN BURNIE, MD 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAY 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN CEMETERY | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
GLEN BURNIE ANNE ARUNDEL MD | | 23e. DATE REC'D. BY REGISTRAR
MAY 31 1983 | | | |
| 24. FUNERAL DIRECTOR NAME
ROBERT S. BARRANCO | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Canfield | | | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 1 1 8 7 9
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Robert Harding ROSE | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 25 83 | | | 2b. HOUR
6⁵⁰ P. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept 20, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | | 7. IF UNDER 1 YEAR MONTHS DAYS
YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. Patent Examiner | | 12b. KIND OF BUSINESS OR INDUSTRY
ENGINEERING | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
83 Bay Drive, Bay Ridge | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frederick G. Rose | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Julia Smith | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
219-42-4218 | | 17. INFORMANT ADDRESS
Ruth Wittler-Rose #13 | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumococcal Pneumonia
4810
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
1967 Present | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/24 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Peter F. VerKouw MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
5/25/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER F. VERKOUW | | | | | | 22e. ADDRESS
1419 Forest Dr. Annapolis | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IF Y) | | | 23b. DATE
5/28/83 | | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore City MD. | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral/Chapel | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 27 1983 | | | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Canine | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar's office. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Robert Harding ROSE

Male

White hair color

Wash DC

U.S.A.

Anne Arundel

Annapolis

Anne Arundel Co. Md.

Md.

A.A.

Annapolis

X

83 Bay View

Bay Ridge

Fredrick G. ROSE

Talia

Yes

W.I.T. surveyor

Rocky Mtn. - Rose

#13

unmarried

X

83

Spa

W.D.

Barrel

2/28/83

W.D.

W.D.

W.D.

W.D.

W.D.

Taylor Funeral Home

W.D.

W.D.

W.D.

W.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 8 0
REG. NO. EDT

| | | | | | |
|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | M | |
| PALMER ERNEST ROSENWINKLE | | MAY 30, 1983 | | 802 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 8. IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | 81 YRS. | IF UNDER 24 HRS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | ANNE ARUNDEL COUNTY MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Bricklayer | | Construction |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | |
| Maryland | | A.A. | Glen Burnie | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 200 Lincoln Ave (21061) | |
| Gustav A. Rosenwinkle | | Melvina Bell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Daughter) ADDRESS | | |
| No | | N/A | Same as 13 | | |
| | | 217.03.7019 | Mrs. Doris M. Williams | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <i>granular degeneration</i> | | | | | <i>10h</i> |
| 5570 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) <i>rupture of sigmoid colon</i> | | | | | <i>8 1/2h</i> |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>COPD</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 5/20 | | <i>rupture of sigmoid colon</i> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| <input type="checkbox"/> | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | |
| | | | | 5/20 1983 | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/20</i> 19 <i>5/20</i> 19 <i>5/20</i> 19, that (I) (we) last saw the deceased alive on <i>5/20</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <i>Sergio V. Alvarez</i> | | | | <i>5/30/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. ATTENDING MEDICAL STAFF | |
| SERGIO V. ALVAREZ, M.D. | | 300 HOSPITAL DRIVE 134 | | PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| | | GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | 2 June 83 | Glen Haven Mem. Pk. | | CITY OR TOWN COUNTY STATE | |
| | | | | Glen Burnie, A.A., MD. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | JUN 2 1983 | | <i>John J. Connel</i> | |
| Singleton Funeral Home/Glen Burnie MD | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 83 11881 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 25 83 | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
(TYPE OR PRINT) Dorothy Dawson Ross | | | | 2b. HOUR 10 AM | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 10 16 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BROOKLYN NY | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 401 MONTEREY AVE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY STATE OF MD. | |
| 13a. STATE MD. 13b. COUNTY AA. 13c. CITY OR TOWN ANNAPOLIS | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 401 MONTEREY AV 21401 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROLAND S. DAWSON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE EDSALL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS BARBARA R. ERICSON BELFAST ME. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
4519 IMMEDIATE CAUSE (a) Pulmonary Embolus
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Phlebitis
DUE TO, OR AS A CONSEQUENCE OF
(c) 2 yrs
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: C.O.P.D., Polycythemia. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 8/5 19 70 to 5/25 19 83, that (I) (we) saw the deceased alive on 5/18 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Rodney L. Brimhall MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/25/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY BRIMHALL | | 22e. ADDRESS FOREST DR. ANNAPOLIS MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 5-29-83 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. MD | |
| 24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL ANNAPOLIS MD ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 27 1983 John J. Carver | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11882

| | | | | | | | | | | | |
|--|---------|------------------------------|-------------------|--|---|--------------------------------------|---------------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| James Robert Rothgeb Jr. | | | | 5-3-1983 | | | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | | | | |
| Male | White | Sept. 16, 1955 | 55 YRS. | U.S.A. | <input checked="" type="checkbox"/> NEVER MARRIED | Anne Arundel County | Glen Burnie | | | | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | | |
| Maryland | | U.S.A. | | | | Anne Arundel County | | Glen Burnie | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| North Arundel Hospital | | | | Mechanic | | | | Civil Serv. | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| Maryland | | | | Anne Arundel | | | | Harmans | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16. SOCIAL SECURITY NO. | | | |
| James R. Rothgeb, Sr. | | | | Freida Lucille Cunningham | | | | 218.22.3604 | | | |
| 17. INFORMANT (Wife) | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | 19. DATE OF OPERATION | | | |
| Mrs. Shirley A. Rothgeb | | | | PART I DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | 20. AUTOPSY?
body only
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED | | | |
| | | | | P.M. 19 | | | | ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2 | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET, FACTORY, FARM, ETC.) | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | 22b. DATE | | | | 22c. NAME OF CEMETERY OR CREMATORY | | | |
| ACTUAL SIGNATURE <u>Dennis F. Smyth M.D.</u> | | | | TITLE (SPECIFY) Assistant | | | | 22d. LOCATION | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn Street, Baltimore Md. | | | | 22e. DATE REC'D. BY REGISTRAR | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE May 83 | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Name SINGLETON Funeral Home | | | | Glen Burnie, MD. | | | | MAY 6 1983 | | | |

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES



W
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Entry 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified for an autopsy.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8311883 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Donald Earl Ruland | | | | 2b. HOUR
8:20 P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH DAY MONTH YEAR
1, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
74 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hsp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Welder | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Benjamin Ruland | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Loucks | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
109-05-7879 | |
| 17. INFORMANT
Donald Ruland | | 18. ADDRESS
Same as #13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
4149 IMMEDIATE CAUSE (a) Cardiac Arrest
(b) Coronary Artery Disease
(c) DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/22, 1978, to 5/31, 1983, that (I) (we) last saw the deceased alive on 5/24, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R.I. Hochman, MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6/1/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R.I. Hochman | | 22e. ADDRESS
16 Mueser Ave Annapolis, Md 2140 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | |
| 23b. DATE
June 3, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
St Vincent de Paul | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Cobleskill Schoharie NY | | | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral Chapel-Annapolis, MD | | ADDRESS
Annapolis, MD | | 25a. DATE REC'D. BY REGISTRAR
JUN 6 1983 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. 8 3 1 1 8 8 4 | | | | | | |
|--|--|--|--|---|--|--|---|--|-----------------------------|--|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Douglas Walsh Russell | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-27-83 | | | | | 2b. HOUR
4 PM | | | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
11-21-05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Pipe Fitter | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Civil Service | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
309 State Street 21403 | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Hicks Russell | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Helen Brown | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)
Yes | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE)
WW II 216 44 9466 | | 17. INFORMANT ADDRESS
Leona B. Russell | | | Same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal Aortic Aneurysm 4414
DUE TO, OR AS CONSEQUENCE OF (b) Past ext Renal Failure
DUE TO, OR AS CONSEQUENCE OF (c) Past ext Respiratory Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yr
2 wk
2 wk | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Long hx of Diabetes and peripheral vascular disease | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
7 | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan. 19 77, to May 27 19 83, that (I) (last saw the deceased alive on) May 27 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 23. SIGNATURE
Gary M. Richardson M.D. | | | | | DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
5-27-83 | | | |
| 27a. PHYSICIAN'S NAME (TYPE OR PRINT)
Gary M. Richardson M.D. | | | | | 27a. ADDRESS
104 Foxbes Street, Annapolis MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | 23b. DATE
May 29, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Annapolis A.A. MD | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral Chapel - Annapolis MD | | | | | 24. ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1983 | | | | | 25. REGISTRAR'S SIGNATURE
John J. Connel | |

Handwritten notes on lined paper, including the word "Handwritten" and various illegible scribbles.

Handwritten notes on lined paper, including the word "Handwritten" and various illegible scribbles.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 8 8 5

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Willie | | | FIRST MIDDLE LAST SAMPSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-18-83 | | | 2b. HOUR 1-42 | | |
| 3. SEX m | | | 4. RACE B | | | 5. DATE OF BIRTH MONTH DAY YEAR 2-25-24 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY A.A. | | | 13c. CITY OR TOWN ANNAPOLIS | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS 14 E. Bens Drive | | | 14. FATHER'S NAME FIRST MIDDLE LAST WILLIE SAMPSON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTIE SAMPSON | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | |
| 16b. SOCIAL SECURITY NO. W.W.II | | | 17. INFORMANT ADDRESS Md. 21403 ALICE C. SAMPSON 14 E. Bens Dr. Annapolis. | | | | | | | | |

MEDICAL CERTIFICATION

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4275
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. **Chronic Mycobacterial (avium) lung infection / Diabetes mellitus**

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from **MAY 9**, 19**83**, to **MAY 18**, 19**83**, that (I) (last) saw the deceased alive on **MAY 17**, 19**83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

| | | | | | | | |
|--|--|---|--|--|--|--------------------------------------|--|
| 22b. SIGNATURE Charles W. Kinzer | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED May 18, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. KINZER MD. | | 22e. ADDRESS ANNAPOLIS, MARYLAND | | | | | |

| | | | | | | | |
|---|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-22-1983 | | 23c. NAME OF CEMETERY OR CREMATORY SANDS HILL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton North Carolina | |
|---|--|----------------------------|--|---|--|---|--|

| | | | | | |
|--|--|--|--|---|--|
| 24. FUNERAL DIRECTOR Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A. | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1983 | | 25b. REGISTRAR'S SIGNATURE Sam J. Conner | |
|--|--|--|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 354-1234.

| FOR
1 - STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 3 3 1 1 8 8 DS0
REG. NO. | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FREDERICK W SANDER | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 26, 1983 | | 2b. HOUR
AM PM
1151 AM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
April 17, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Odenton | 13d. INSIDE CITY HOUSES?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fritz Sanders | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Sour | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-03-3793 | | 17. INFORMANT
ADDRESS
Garnet Sander # 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4100 Cardiac Arrest
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1979 to May 26, 1983 , that (I) (we) lost saw the deceased alive on May 4, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Paul S. Rhodes | | DEGREE
Attending Physician | | 22c. DATE SIGNED
5-27-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL S. RHODES, M.D. | | 22e. ADDRESS
1667 CROFTON CENTER CROFTON, MARYLAND, 21114 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
5-28-83 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Howard Md. | |
| 24. FUNERAL DIRECTOR
NAME
T.A. Hardesty | | ADDRESS
Annapolis Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |

BP

ST-3

20, 1963 11:51 AM

MAY

SAUNDERS

PREPARED BY

AND ARTHUR CORBY

NORTH ARTHUR HOSPITAL

CLIN BUREAU

1001 GRAFTON CENTER
GRAFTON, MASSACHUSETTS 01534

PAUL S. HODGE, M.D.

MAY 21 1963

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DRAIN IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETURN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11887 | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) Edward F Schindel | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED 05 16 83 | | 2b. HOUR 1 AM | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR 04 23 07 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 76 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD | | | | 2d. DATE PRONOUNCED DEAD 05 16 83 | |
| 10. CITY OR TOWN OF DEATH
Annapolis Md | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A A Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Self Employed Tavern Owner | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
New Jersey | | 13b. COUNTY
Monmouth | | 13c. CITY OR TOWN
Spring Lake | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
210 Lorraine Ave. 07762 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Schindel | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Plakcinski | | | | 17. INFORMANT ADDRESS
Stephanie S. Schindel Same as 13e | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
145-01-1553 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4019 IMMEDIATE CAUSE (a) Cardiac arrest.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Hypertension
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
George E. Luchardt M.D. | | | | TITLE (SPECIFY)
Deputy Medical Examiner | | | | DATE SIGNED
5/16/83 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
G LINTHARDT MD | | | | ADDRESS
312 Washington St Annapolis | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
5-19-83 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Catharine's Wall Township Monmouth New Jersey | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert E. Evans | | | | ADDRESS
1212 West St. Annapolis, Md. | | 25a. DATE REC'D BY REGISTRAR
MAY 23 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carroll | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|--|---|---|---|----------------------------|---|---|
| 1. DECEASED-NAME
(Type or print) John Sylvester Segelken | | | 2a. DATE OF DEATH
Month May Day 30 Year 1983 | | | 2b. HOUR
P. M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
June 11, 1901 | | 6. AGE (In years last birthday)
81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Anne Arundel Md. | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
North Arundel Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Contractor (Ret.) | | 12b. KIND OF BUSINESS OR INDUSTRY
Building | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. CITY OR TOWN
Anne Arundel Millersville | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Lot 40, Rol Park Trailer Village | | | |
| 14. FATHER'S NAME First Middle Last
Frederick Segelken | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Elizabeth Vogt | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
NO | | | 16b. SOCIAL SECURITY NO.
213-16-4621 | | 17. INFORMANT
Sarah I. Segelken | | Address same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Renal failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (c) 10 chronic heart disease (a) Myocardial infarction
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
1 month
1 month |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/6/82 , 19 82 , to 5/31/83 , 19 83 ; that (I) (we) last saw the deceased alive on 5/30/83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
General Blum | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/31/83 | | | |
| 22d. PHYSICIAN'S NAME (Type)
GOVERNOR CHURCH | | | | 22e. ADDRESS
8 EVERETT AVE ANNAPOLIS MD 21406 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
June 2, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest | | 23d. LOCATION (City or Town) (County) (State)
Annapolis A.A. MD | | | |
| 24. FUNERAL DIRECTOR
Taylor Funeral Chapel - Annapolis, MD | | | | 25a. REC'D BY REGISTRAR
JUN 1 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

John Sylvester Engelken
June 1888
White
MS
MSA

John Sylvester Engelken
June 1888
White
MS
MSA

John Sylvester Engelken
June 1888
White
MS
MSA

John Sylvester Engelken
June 1888
White
MS
MSA

John Sylvester Engelken
June 1888
White
MS
MSA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 8 9
REG. NO. | | | | EDT | |
|--|--|---|--|---|--|---|--|--|--|--|--|--------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANTHONY Frederick SEUFERT | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 20 1983 | | | | 2b. HOUR
141 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 7. 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7. IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Civil Serv. | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS -Garland Park-
102 Linden Avenue 21061 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Philip P. Seufert | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Teresa Suchsbradl | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. I 217.52.6061 | | 17. INFORMANT (Wife)
Mrs. Viola M. Seufert | | ADDRESS
Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Myocardial Infarction
(c) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 23a. SIGNATURE
JOSE M. PRESBITERO, M.D. | | | | | | | | DEGREE | | 23c. DATE SIGNED
5/19/83 | | | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSE M. PRESBITERO, M.D. | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 23d. ADDRESS
325 HOSPITAL DRIVE SUITE 108
GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
24 May 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Balt., MD. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
R. H. Hyslop | | | | ADDRESS
MD.
Singleton Funeral Home / Glen Burnie | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connelley | | | | | |

BP

17

1941 MAY 20 10:11 AM

WASH. AIRPORT

CLASS SECRET

325 HOSPITAL DRIVE SUITE 108

NEW YORK, N.Y. 10017

JOSE M. PEREZ, N.Y.

1941 MAY 20 10:11 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 83 11890
REG. NO. | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MARY MIDDLE LEE LAST Singletary | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-26-83 | | 2b. HOUR
8:54 M |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH MONTH DAY YEAR
9-25-17 | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
TEXAS | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL CO. MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DEPUTY SHERIFF | | 12b. KIND OF BUSINESS OR INDUSTRY
POLICE |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE TEXAS 13b. COUNTY HARRIS 13c. CITY OR TOWN PORTER | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST JAMES MIDDLE WASHINGTON LAST ATKINSON | | | 15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE THOMPSON LAST THOMPSON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
467-14-3359 | 17. INFORMANT ADDRESS
DON MEDFORD 2101 S. Lang Ave. Deniso | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 2 PROBABLE WALL RUPTURE
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
~3 days |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/22 1983 to 5/26 1983 that (I) (we) last saw the deceased alive on 5/26 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
JACOB E. TETTELBAUM | | | | 22c. DATE SIGNED
5/17/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JACOB E. TETTELBAUM | | | | 22e. ADDRESS
139 old locomotive (sum 2140) | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/31/83 | 23c. NAME OF CEMETERY OR CREMATORY
ROSEWOOD MEM. PK. | | 23d. LOCATION
HUMBLE COUNTY TEXAS |
| 24. FUNERAL DIRECTOR
HARDESTY FUNERAL HOME 12 RIDGELY AVE. ANN MD | | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1983 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 9 EDT
REG. NO. | | | |
|---|--|---|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
HARRY WEBSTER SMITH | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 7, 1983 | | | | 2b. HOUR
1130 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
June 25 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Pipefitter(ret) | | | 12b. KIND OF BUSINESS OR INDUSTRY
B&O Railroad | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE
Md. | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Glen Burnie | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS
1 Wendover Rd. | | | | 21061 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles A. Smith | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lydia Jefferson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
Na | | 17. INFORMANT (wife)
Mrs Eunice M. Smith | | ADDRESS
Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u>
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Atherosclerotic Heart Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
56 days
years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Chronic Renal Failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-17-83</u> to <u>5-7-83</u> , that (I) (we) lost saw the deceased alive on <u>5-7-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John J. Conner</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5-8-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John J. Conner | | | | 22e. ADDRESS
301 Hospital Dr. Glen Burnie Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
May 10 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. | | | |
| 24. FUNERAL DIRECTOR'S NAME
<u>Sam R. Charlton</u> | | | | ADDRESS
Singleton Funeral Home Glen Burnie Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 10 1983 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Conner</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 3 1 1 8 9 2
REG. NO. | DST |
|--|--|--|--|---|--|---|---|--|--|--|-----|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY Lavinia SMITH | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 29, 1983 | | | 2b. HOUR A.
7:41 M. | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
6 3 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
58 | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Packer | | | 12b. KIND OF BUSINESS OR INDUSTRY
Austin Packing Co. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
ARM | | 13c. CITY OR TOWN
Brooklyn Pk. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
110 Bon Air Road 21225 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Stanley Lundberg | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Maude Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
216-36-0607 | | 17. INFORMANT ADDRESS
Christopher Brown 1701 Harman Avenue 21230 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 3, 1983 to May 28, 1983 , that (I) (we) last saw the deceased alive on May 28, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Ira E. Kaplan | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/29/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
IRA E. KAPLAN, M.D. | | | | 22e. ADDRESS
7845 Oakwood Road, #200
Glen Burnie, Maryland, 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
6/2/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME
Hubbard Funeral Home, Inc. | | | | ADDRESS
4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 31 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. L... | |

MEDICAL CERTIFICATION

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 8 9 3
REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Vinton Smith | | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 1, 1983 | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
3 9 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Gardener | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Annapolis | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ED SMITH | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ROSE MAYNARD | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
291610776 | | 17. INFORMANT ADDRESS
ANNETTE GORDON 80 Clay St. Annapolis, Md. 21401 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic Carcinoma of Pancreas</u>
1579
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION
3/25/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma Pancreas | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
2124 | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
83 5/1 83 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1/83</u> to <u>5/1/83</u> , that (I) (we) last saw the deceased alive on <u>5/1/83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John W. Mahoney, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/1/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
Gardens Avenue Annapolis Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5-4-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
PINELAWN MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Annapolis A.A. Maryland | |
| 24. FUNERAL DIRECTOR
WILLIAM REESE & SONS MORTUARY, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 3 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Canine | |

1998-1999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 3 1 1 8 9 4
REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
HELEN SNEERINGER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 21 83 | | | 2b. HOUR
6 ³⁰ A.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
OCTOBER 21, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MINNESOTA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
906 POPLAR ST. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SELF EMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY
LAUNDROMAT | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ARUNDEL | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
906 POPLAR ST. 21401 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
EMIL SCHOENINGE | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LAURA MONTGOMERY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
476-10-5222 | | 17. INFORMANT ADDRESS
TOM SNEERINGER, 217 E. 22ND ST. NEW YORK, NY | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESP ARREST</u>
1919
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>GLIOBLASTOMA (L) TEMPORAL LOBE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 mos | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 19 83</u> to <u>MAY 18 83</u> , that (I) (we) last saw the deceased alive on <u>MAY 18 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Barry R. Nathanson</u> MD | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
5/21/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY R. NATHANSON | | | | | 22e. ADDRESS
121 CATHEDRAL ST. ANNAP MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5/23/83 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. ANNES CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNAPOLIS ANNE ARUNDEL MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC. WASHINGTON, D.C. 20036 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 1 8 9 5 | |
|--|-------------------------|---|---|---|--------------------------------|---|--|---|-------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Joseph A. Spriggs | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5-3-1983 | | 2b. HOUR 7:00 PM | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR 3 13 66 | 6. AGE (IN YEARS LAST BIRTHDAY)
17 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD 5-3-1983 | | 2d. HOUR 7:00 PM | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1117 N. Fulton Ave. 21217 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Norman M. Spriggs | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hilda R. Lewis | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-84-8079 | | 17. INFORMANT
Hilda Spriggs | | 17. ADDRESS
1117 N. Fulton Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
9360 IMMEDIATE CAUSE (a) Hanging
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR 5:00 P.M. MONTH DAY YEAR 5-3 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject hanged self | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
7910 Darien Dr., Glen Burnie, A.A.Co., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
5-4-83 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn Street, Baltimore, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/7/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 5 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carter</i> | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE RELEASE THE CERTIFICATE TO THE MEDICAL EXAMINER IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGES 4, 5, AND 6 TO THE MEDICAL EXAMINER. PAGES 7, 8, AND 9 TO THE FUNERAL HOME. PAGES 10, 11, AND 12 TO THE MEDICAL EXAMINER. PAGES 13, 14, AND 15 TO THE FUNERAL HOME. PAGES 16, 17, AND 18 TO THE MEDICAL EXAMINER. PAGES 19, 20, AND 21 TO THE FUNERAL HOME. PAGES 22, 23, AND 24 TO THE MEDICAL EXAMINER. PAGES 25, 26, AND 27 TO THE FUNERAL HOME. PAGES 28, 29, AND 30 TO THE MEDICAL EXAMINER. PAGES 31, 32, AND 33 TO THE FUNERAL HOME. PAGES 34, 35, AND 36 TO THE MEDICAL EXAMINER. PAGES 37, 38, AND 39 TO THE FUNERAL HOME. PAGES 40, 41, AND 42 TO THE MEDICAL EXAMINER. PAGES 43, 44, AND 45 TO THE FUNERAL HOME. PAGES 46, 47, AND 48 TO THE MEDICAL EXAMINER. PAGES 49, 50, AND 51 TO THE FUNERAL HOME. PAGES 52, 53, AND 54 TO THE MEDICAL EXAMINER. PAGES 55, 56, AND 57 TO THE FUNERAL HOME. PAGES 58, 59, AND 60 TO THE MEDICAL EXAMINER. PAGES 61, 62, AND 63 TO THE FUNERAL HOME. PAGES 64, 65, AND 66 TO THE MEDICAL EXAMINER. PAGES 67, 68, AND 69 TO THE FUNERAL HOME. PAGES 70, 71, AND 72 TO THE MEDICAL EXAMINER. PAGES 73, 74, AND 75 TO THE FUNERAL HOME. PAGES 76, 77, AND 78 TO THE MEDICAL EXAMINER. PAGES 79, 80, AND 81 TO THE FUNERAL HOME. PAGES 82, 83, AND 84 TO THE MEDICAL EXAMINER. PAGES 85, 86, AND 87 TO THE FUNERAL HOME. PAGES 88, 89, AND 90 TO THE MEDICAL EXAMINER. PAGES 91, 92, AND 93 TO THE FUNERAL HOME. PAGES 94, 95, AND 96 TO THE MEDICAL EXAMINER. PAGES 97, 98, AND 99 TO THE FUNERAL HOME. PAGES 100, 101, AND 102 TO THE MEDICAL EXAMINER. PAGES 103, 104, AND 105 TO THE FUNERAL HOME. PAGES 106, 107, AND 108 TO THE MEDICAL EXAMINER. PAGES 109, 110, AND 111 TO THE FUNERAL HOME. PAGES 112, 113, AND 114 TO THE MEDICAL EXAMINER. PAGES 115, 116, AND 117 TO THE FUNERAL HOME. PAGES 118, 119, AND 120 TO THE MEDICAL EXAMINER. PAGES 121, 122, AND 123 TO THE FUNERAL HOME. PAGES 124, 125, AND 126 TO THE MEDICAL EXAMINER. PAGES 127, 128, AND 129 TO THE FUNERAL HOME. PAGES 130, 131, AND 132 TO THE MEDICAL EXAMINER. PAGES 133, 134, AND 135 TO THE FUNERAL HOME. PAGES 136, 137, AND 138 TO THE MEDICAL EXAMINER. PAGES 139, 140, AND 141 TO THE FUNERAL HOME. PAGES 142, 143, AND 144 TO THE MEDICAL EXAMINER. PAGES 145, 146, AND 147 TO THE FUNERAL HOME. PAGES 148, 149, AND 150 TO THE MEDICAL EXAMINER. PAGES 151, 152, AND 153 TO THE FUNERAL HOME. PAGES 154, 155, AND 156 TO THE MEDICAL EXAMINER. PAGES 157, 158, AND 159 TO THE FUNERAL HOME. PAGES 160, 161, AND 162 TO THE MEDICAL EXAMINER. PAGES 163, 164, AND 165 TO THE FUNERAL HOME. PAGES 166, 167, AND 168 TO THE MEDICAL EXAMINER. PAGES 169, 170, AND 171 TO THE FUNERAL HOME. PAGES 172, 173, AND 174 TO THE MEDICAL EXAMINER. PAGES 175, 176, AND 177 TO THE FUNERAL HOME. PAGES 178, 179, AND 180 TO THE MEDICAL EXAMINER. PAGES 181, 182, AND 183 TO THE FUNERAL HOME. PAGES 184, 185, AND 186 TO THE MEDICAL EXAMINER. PAGES 187, 188, AND 189 TO THE FUNERAL HOME. PAGES 190, 191, AND 192 TO THE MEDICAL EXAMINER. PAGES 193, 194, AND 195 TO THE FUNERAL HOME. PAGES 196, 197, AND 198 TO THE MEDICAL EXAMINER. PAGES 199, 200, AND 201 TO THE FUNERAL HOME. PAGES 202, 203, AND 204 TO THE MEDICAL EXAMINER. PAGES 205, 206, AND 207 TO THE FUNERAL HOME. PAGES 208, 209, AND 210 TO THE MEDICAL EXAMINER. PAGES 211, 212, AND 213 TO THE FUNERAL HOME. PAGES 214, 215, AND 216 TO THE MEDICAL EXAMINER. PAGES 217, 218, AND 219 TO THE FUNERAL HOME. PAGES 220, 221, AND 222 TO THE MEDICAL EXAMINER. PAGES 223, 224, AND 225 TO THE FUNERAL HOME. PAGES 226, 227, AND 228 TO THE MEDICAL EXAMINER. PAGES 229, 230, AND 231 TO THE FUNERAL HOME. PAGES 232, 233, AND 234 TO THE MEDICAL EXAMINER. PAGES 235, 236, AND 237 TO THE FUNERAL HOME. PAGES 238, 239, AND 240 TO THE MEDICAL EXAMINER. PAGES 241, 242, AND 243 TO THE FUNERAL HOME. PAGES 244, 245, AND 246 TO THE MEDICAL EXAMINER. PAGES 247, 248, AND 249 TO THE FUNERAL HOME. PAGES 250, 251, AND 252 TO THE MEDICAL EXAMINER. PAGES 253, 254, AND 255 TO THE FUNERAL HOME. PAGES 256, 257, AND 258 TO THE MEDICAL EXAMINER. PAGES 259, 260, AND 261 TO THE FUNERAL HOME. PAGES 262, 263, AND 264 TO THE MEDICAL EXAMINER. PAGES 265, 266, AND 267 TO THE FUNERAL HOME. PAGES 268, 269, AND 270 TO THE MEDICAL EXAMINER. PAGES 271, 272, AND 273 TO THE FUNERAL HOME. PAGES 274, 275, AND 276 TO THE MEDICAL EXAMINER. PAGES 277, 278, AND 279 TO THE FUNERAL HOME. PAGES 280, 281, AND 282 TO THE MEDICAL EXAMINER. PAGES 283, 284, AND 285 TO THE FUNERAL HOME. PAGES 286, 287, AND 288 TO THE MEDICAL EXAMINER. PAGES 289, 290, AND 291 TO THE FUNERAL HOME. PAGES 292, 293, AND 294 TO THE MEDICAL EXAMINER. PAGES 295, 296, AND 297 TO THE FUNERAL HOME. PAGES 298, 299, AND 300 TO THE MEDICAL EXAMINER. PAGES 301, 302, AND 303 TO THE FUNERAL HOME. PAGES 304, 305, AND 306 TO THE MEDICAL EXAMINER. PAGES 307, 308, AND 309 TO THE FUNERAL HOME. PAGES 310, 311, AND 312 TO THE MEDICAL EXAMINER. PAGES 313, 314, AND 315 TO THE FUNERAL HOME. PAGES 316, 317, AND 318 TO THE MEDICAL EXAMINER. PAGES 319, 320, AND 321 TO THE FUNERAL HOME. PAGES 322, 323, AND 324 TO THE MEDICAL EXAMINER. PAGES 325, 326, AND 327 TO THE FUNERAL HOME. PAGES 328, 329, AND 330 TO THE MEDICAL EXAMINER. PAGES 331, 332, AND 333 TO THE FUNERAL HOME. PAGES 334, 335, AND 336 TO THE MEDICAL EXAMINER. PAGES 337, 338, AND 339 TO THE FUNERAL HOME. PAGES 340, 341, AND 342 TO THE MEDICAL EXAMINER. PAGES 343, 344, AND 345 TO THE FUNERAL HOME. PAGES 346, 347, AND 348 TO THE MEDICAL EXAMINER. PAGES 349, 350, AND 351 TO THE FUNERAL HOME. PAGES 352, 353, AND 354 TO THE MEDICAL EXAMINER. PAGES 355, 356, AND 357 TO THE FUNERAL HOME. PAGES 358, 359, AND 360 TO THE MEDICAL EXAMINER. PAGES 361, 362, AND 363 TO THE FUNERAL HOME. PAGES 364, 365, AND 366 TO THE MEDICAL EXAMINER. PAGES 367, 368, AND 369 TO THE FUNERAL HOME. PAGES 370, 371, AND 372 TO THE MEDICAL EXAMINER. PAGES 373, 374, AND 375 TO THE FUNERAL HOME. PAGES 376, 377, AND 378 TO THE MEDICAL EXAMINER. PAGES 379, 380, AND 381 TO THE FUNERAL HOME. PAGES 382, 383, AND 384 TO THE MEDICAL EXAMINER. PAGES 385, 386, AND 387 TO THE FUNERAL HOME. PAGES 388, 389, AND 390 TO THE MEDICAL EXAMINER. PAGES 391, 392, AND 393 TO THE FUNERAL HOME. PAGES 394, 395, AND 396 TO THE MEDICAL EXAMINER. PAGES 397, 398, AND 399 TO THE FUNERAL HOME. PAGES 400, 401, AND 402 TO THE MEDICAL EXAMINER. PAGES 403, 404, AND 405 TO THE FUNERAL HOME. PAGES 406, 407, AND 408 TO THE MEDICAL EXAMINER. PAGES 409, 410, AND 411 TO THE FUNERAL HOME. PAGES 412, 413, AND 414 TO THE MEDICAL EXAMINER. PAGES 415, 416, AND 417 TO THE FUNERAL HOME. PAGES 418, 419, AND 420 TO THE MEDICAL EXAMINER. PAGES 421, 422, AND 423 TO THE FUNERAL HOME. PAGES 424, 425, AND 426 TO THE MEDICAL EXAMINER. PAGES 427, 428, AND 429 TO THE FUNERAL HOME. PAGES 430, 431, AND 432 TO THE MEDICAL EXAMINER. PAGES 433, 434, AND 435 TO THE FUNERAL HOME. PAGES 436, 437, AND 438 TO THE MEDICAL EXAMINER. PAGES 439, 440, AND 441 TO THE FUNERAL HOME. PAGES 442, 443, AND 444 TO THE MEDICAL EXAMINER. PAGES 445, 446, AND 447 TO THE FUNERAL HOME. PAGES 448, 449, AND 450 TO THE MEDICAL EXAMINER. PAGES 451, 452, AND 453 TO THE FUNERAL HOME. PAGES 454, 455, AND 456 TO THE MEDICAL EXAMINER. PAGES 457, 458, AND 459 TO THE FUNERAL HOME. PAGES 460, 461, AND 462 TO THE MEDICAL EXAMINER. PAGES 463, 464, AND 465 TO THE FUNERAL HOME. PAGES 466, 467, AND 468 TO THE MEDICAL EXAMINER. PAGES 469, 470, AND 471 TO THE FUNERAL HOME. PAGES 472, 473, AND 474 TO THE MEDICAL EXAMINER. PAGES 475, 476, AND 477 TO THE FUNERAL HOME. PAGES 478, 479, AND 480 TO THE MEDICAL EXAMINER. PAGES 481, 482, AND 483 TO THE FUNERAL HOME. PAGES 484, 485, AND 486 TO THE MEDICAL EXAMINER. PAGES 487, 488, AND 489 TO THE FUNERAL HOME. PAGES 490, 491, AND 492 TO THE MEDICAL EXAMINER. PAGES 493, 494, AND 495 TO THE FUNERAL HOME. PAGES 496, 497, AND 498 TO THE MEDICAL EXAMINER. PAGES 499, 500, AND 501 TO THE FUNERAL HOME. PAGES 502, 503, AND 504 TO THE MEDICAL EXAMINER. PAGES 505, 506, AND 507 TO THE FUNERAL HOME. PAGES

BP_____

DHMH - 17
(VR A15 ME (5))
20M 4/82

| 1- STATE REGISTRAR | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 | | REG. NO. 11897 | |
|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | |
| Robert | | Earl | | Stewart | | Jr. | | <input checked="" type="checkbox"/> MONTH
<input type="checkbox"/> 5 9 1983 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7c. DATE PRONOUNCED DEAD | |
| MALE | | WHITE | | DEC. 8, 1964 | | 18 YRS. | | 5 9 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 7d. HOUR | |
| JAPAN | | | | | | Anne Arundel County | | 4:42 P.M. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Glen Burnie | | North Arundel Hospital | | SHIPPING CLERK | | ELECTRONIC | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MARYLAND | | ANNE ARUNDEL | | SEVERN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7850 BASTILLE PL. SEVERN, MD | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| ROBERT | | BARBARA | | 219-76-5960 | | ROBERT E. STEWART | | SEVERN, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| IMMEDIATE CAUSE (a) Drowning | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | 1:45 P.M. 5 9 1983 | | Subject in canoe that overturned | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | |
| | | water | | Severn & Reece Rds. | | Anne Arundel County | | MD | |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | 5/10/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | |
| Thomas D. Smith, M.D. | | 111 Penn Street, Baltimore, MD | | 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | |
| BURIAL | | 5/12/83 | | MEADOERIDGE CEMETERY | | DORSEY | | MD | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | | | | | |
| HARDESTY FUNERAL HOME 12 RIDGELY AVE., ANN., MD | | MAY 13 1983 | | John J. Carver | | | | | |

(14)

CONFIDENTIAL

NOV 1 1983

NOV 1 1983

NOV 1 1983

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY OTHER INFORMATION IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11898

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|-------------------------|--|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) John R. Sweeney | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH 5 DAY 9 YEAR 1983 | | | 2b. HOUR AM | | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH 9 DAY 1 YEAR 1927 | 6. AGE (IN YEARS)
LAST BIRTHDAY 55 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN 0 | 2c. DATE PRONOUNCED DEAD
MONTH 5 DAY 9 YEAR 1983 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASS. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
BETHLEHEM STEEL | | 12b. KIND OF BUSINESS OR INDUSTRY
STEEL | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
ANNAPO LIS | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST JOHN MIDDLE S LAST SWEENEY | | 15. MOTHER'S MAIDEN NAME
FIRST EDITH MIDDLE C LAST CARNEY | | 16. SOCIAL SECURITY NO.
103 20 7531 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
103 20 7531 | | 17. INFORMANT
BARBARA A. SWEENEY ADDRESS Same as #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
Body <input checked="" type="checkbox"/> Only <input type="checkbox"/>
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | Body only | | | | | |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 22b. I certify that I took charge of the remains described above, held on | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | Deputy Chief | | | DATE SIGNED 5/10/83 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Thomas D. Smith, M.D. | | | ADDRESS 111 Penn Street, Baltimore, MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(BY) | | 23b. DATE
5/13/83 | | 23c. NAME OF CEMETERY OR CREMATORY
ST MARY'S Cem. | | 23d. LOCATION
CITY OR TOWN ANNAPO LIS COUNTY AA. STATE MD. | | |
| 24. FUNERAL DIRECTOR
NAME TAYLOR FUNERAL CHAPEL ADDRESS 21401 ANNAPOLIS MD | | | 25a. DATE REC'D. BY REGISTRAR
MAY 12 1983 | | | 25b. REGISTRAR'S SIGNATURE John J. Lander | | |

TO: THE ADJUTANT GENERAL
FROM: THE ADJUTANT GENERAL
SUBJECT: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
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5. [illegible]
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97. [illegible]
98. [illegible]
99. [illegible]
100. [illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR
1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 | | | | | | | | | | REG. NO. 11899 | |
|--|--|--------------|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Benjamin Lee Thompson | | | | | | | | | | 20. DATE KNOWN OF DEATH
ESTIMATED May 14, 1983 | | | | | | | | | | 2b. HOUR
10 ⁰⁰ | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR 03 29 56 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 26 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
5/14/83 | | 2d. HOUR
10 ⁰⁰ | | | | | | | |
| 2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A A County | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Hanover | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1364 Dorsey Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Shop Foreman | | | | 12b. KIND OF BUSINESS OR INDUSTRY
ExxonNevamar | | | | | | | | | |
| 13a. STATE
Md. | | | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
Hanover | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1364 Dorsey Road 21076 | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Francis E. Thompson, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Regina C. Lawrence | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
212-60-0871 | | 17. INFORMANT
ADDRESS Sandra Thompson-Hugoniot, same as 13 | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9554 IMMEDIATE CAUSE (a) Gunshot wound to head
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
— | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 850 | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 850 P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
self inflicted qsw | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
George E. Linhardt | | | | TITLE (SPECIFY)
M.D. Dep | | | | MEDICAL EXAMINER
DATE SIGNED 5/14/83 | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) George E. LINHARDT | | | | ADDRESS 312 Washington St. Anna | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
18 May 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Baltimore, Anne Arundel, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME James S. Kirkley, Glen Burnie, Md. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 16 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | | | | | | |

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1) $\Sigma = 0$ PS CO_2 W M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled in when the death is reported to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 1 1 9 0 0
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|-------------------|---|------------|--|---|--|---------------------------------|-------------------------|-----------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Myra J. Tippet | | | | MAY 15 1983 | | | | P _M | |
| 3. SEX | F | 4. RACE | WHITE | 5. DATE OF BIRTH | MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR |
| | | | | 7 13 1911 | | | 71 YRS. | | IF UNDER 24 HRS |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | Va. | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | HUNNE HUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH | Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| | | AA GEN Hospit | | BEAUTICIAN | | | | | |
| 13a. STATE | MD. | 13b. COUNTY | AA | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | 17867 Leilley Rd. 21061 | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14. FATHER'S NAME | FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME | | FIRST MIDDLE LAST | | | | | |
| | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | 578-094927 | 17. INFORMANT | | John Tippet | | | |
| | | | | | | ADDRESS: COLONIAL TRAILER PARK ANNAPOLIS MD. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|---|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED |
| GA Mitchell MD | | | 5-16-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | |
| GA Mitchell MD | 205 Ridgely Ave Annapolis | | |

| | | | |
|--|--------------|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| CREMATION | 5/16/83 | Ft Lincoln | DEERWOOD PG. MD. |
| 24. FUNERAL DIRECTOR
NAME | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR |
| Taylor Funeral Chapel | Annapolis MD | | MAY 17 1983 |

Myself to
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 177 RECORDS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11901 | | | |
|--|--|------------------|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ELENOR MARGARET TREVATHAN | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
5/17/83 | | 2b. HOUR
A M | |
| 1. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
11/21/03 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN
79 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD
5/17/83 | | 2d. HOUR
11A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
PASADENA | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
111 NORMAN RD. (21122) | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Jens Christen Pedersen | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna Christina Sorensen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | (IF YES, GIVE WAR OR DATES)
N/A | | 16b. SOCIAL SECURITY NO.
544.14.5165 | | 17. INFORMANT -daughter- ADDRESS
Mrs. Bette O'Bitz Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>DROWNING</u>
9540
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
10PM 5/17/83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject committed suicide | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Rock Creek | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
Pasadena A.A. Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
George E. Linhardt, Jr. | | | | TITLE (SPECIFY)
Sub. Dep. | | | | MEDICAL EXAMINER | | DATE SIGNED
5/17/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
George E. Linhardt, Jr., M.D. | | | | ADDRESS
312 Washington St., Annapolis, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
18 May 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Proc. Inc. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Catonsville, Balto., MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME
Dean P. Charlton | | | | Glen Burnie/MD. 21061 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 20 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Canine | | | |

MEDICAL CERTIFICATION



James E. Sullivan

MASS 888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 3 1 1 9 0 2
REG. NO. EDT | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST
BERTHA MARIE TROCHE | | | | | MONTH DAY YEAR HOUR
MAY 18, 1983 1040 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | White | | Nov. 22, 1926 | | 56 YRS. | | MONTHS DAYS HOURS MIN. | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | USA | | | | ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Homemaker | | Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE
Maryland | | A.A. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7253 Simms Rd. (21076) | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST
Clarence Spalding | | | | | FIRST MIDDLE LAST
(U N K N O W N) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT son-in-law ADDRESS | | | | | |
| No | | N/A | | 220-12-5569 Mr. William Meyers (same as # 13) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u>
<u>4140</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arterio-sclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes</u>
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Angiosten heart failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/11/83</u> 19 <u>83</u> , to <u>5/18/83</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5/18/83</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. ADDRESS | | | | 22d. DATE SIGNED | |
| <u>Jorge B. Ramirez, M.D.</u> | | | | 7845 OAKWOOD ROAD, SUITE 205
GLEN BURNIE, MARYLAND 21061 | | | | <u>5/19/83</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | | | 21 May 83 | | Meadowridge Mem. Pk., ElkrIDGE | | Howard, MD. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE RECEIVED BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | |
| <u>Singleton Funeral Home/Glen Burnie, MD.</u> | | | | MAY 20 1983 | | | | <u>John J. Connel</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. Both with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. Both with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| FOR
STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 3 1 1 9 0 3
REG. NO. EDT 3 | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DELBERT VERNON WAGNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 31, 1983 | | 2b. HOUR
A M
3:23 |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 25 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY
NSA |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MARYLAND ANNE ARUNDEL GLEN BURNIE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
317 MARYLAND AVENUE 21061 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BENJAMIN SWARTZ WAGNER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDNA DOXZEN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WWII 1942-46 | | | 16b. SOCIAL SECURITY NO.
216-16-9573 | | 17. INFORMANT
BETTY ANN WAGNER |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
4149
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) years | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
— |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Sang C. Doh</i> | | | | 22c. DATE SIGNED
10-31-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SANG C. DOH, M. D. | | | | 22e. ADDRESS
95 AQUAHART ROAD
GLEN BURNIE, MARYLAND 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
5/31/83 | | 23c. NAME OF CEMETERY OR CREMATORY | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 3 1983 | |
| 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse, it should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and file them in the space provided within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

| FOR
1. STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 3 1 1 9 0 4
REG. NO. | |
|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Frances A. Wagner. | | | 2a. DATE OF DEATH
MONTH DAY YEAR MAY 22 1983 | | 2b. HOUR
7:39 ^P _M |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR AUGUST 18, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | 13c. CITY OR TOWN
ANNAPOLIS | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
(UNKNOWN) | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(UNKNOWN) | | 13e. STREET ADDRESS
Rt. 6-1186 RIVERSIDE RD 21401 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
216-01-6626 | | 17. INFORMANT
ADDRESS
CAROLINE M. PALEN (SAME AS ABOVE) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anteuro-sclerotic Heart Disease
4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DO TO, OR AS A CONSEQUENCE OF (b) _____
DO TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 YRS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9-1 , 19 72 , to 4-13 , 19 83 , that (I) (we) last saw the deceased alive 4-13 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you (we) did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE
Donald Hislop | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-23-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD HISLOP | | 22e. ADDRESS
ROBINSON RD + OWENS WAY SEVERNA PARK MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAY 25 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY CROSS CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE ANNE ARUNDEL MD. | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1983 | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCO | | 501 LESS RICHIE HWY.
SEVERNA PARK, MD. | | 25b. REGISTRAR'S SIGNATURE
John J. Canine | |

BP

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83

REG. NO.

11905

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | | | | | 2b. HOUR AM | | | | | | | |
| George Leon Waltman | | | | | | May 8 1983 12:10 | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| Male | | White | | Nov. 14 1896 | | 86 YRS. | | | | MONTHS DAYS | | HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Balto. Md. | | U.S.A. | | | | A.A. MD. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Glen Burnie | | N. Arundel Hospital | | | | Foreman (ret) | | | | Balto. G.&E. | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 8116 Telegraph Rd. 21144 | | | | | | | | | | | | | |
| Md. | | A.A. | | Severn | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| George J. Waltman | | | | | | Mary E. Woods | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMATION (Daughter) ADDRESS | | | | | | | | | | | |
| No | | | | | | Na | | 212-05-7497 Mrs. Grace E. Smith Same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMATOSIS

1850 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Prostate Cancer
} DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 YEARS | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from February 19 80, to May 19 83, that (I) (we) last saw the deceased alive on April 11 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Raymond G. Herzinger | | | | | | | | | | | | DEGREE
MD.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5-9-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Raymond G. Herzinger | | | | | | | | | | | | 22e. ADDRESS
325 Hospital Dr. Suite 204 Glen Burnie Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Burial | | | | May 11, 1983 | | Glen Haven Mem Pk. Glen Burnie A.A. Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME P. Charlton
Singleton Funeral Home Glen Burnie Md. | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 10 1983 | | | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



RECEIVED
JUN 10 1914

2014



Handwritten signature or initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| FOR
1 - STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 3 1 1 9 0 6
REG. NO. | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Virginia Lee Warner | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 14 83 | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec 2, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
Edgewater | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Lee Chivers | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Quinn | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-18-8986 | |
| 17. INFORMANT
ADDRESS
William Oliver Warner | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure
4151
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary edema
Pneumonitis
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary emboli | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks
2 weeks
2 weeks | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 May 19 83 to 14 May 19 83, that (I) (we) last saw the deceased alive on 14 May 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Charles W. Kinzer | | DEGREE | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles W. Kinzer, M.D., P.A. | | 22e. ADDRESS
16 Murray Ave Annapolis, Md. 21401 | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
May 17, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakemont | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Davidsonville AA MD | |
| 24. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel-Annapolis, MD | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. [Signature] | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 9 0 7
REG. NO. EDT

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DALE E WARREN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 28, 1983 | | 2b. HOUR
250 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
February 24, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Grounds Supervisor | 12b. KIND OF BUSINESS OR INDUSTRY
Airport | |
| 13a. STATE
Maryland | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
4437-1 Mountain Road 21122 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William E. Warren | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Swanger | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
11 220-16-1834 | | 17. INFORMANT
503 Edgewater Road Pasadena, Md.
Mrs. Kathryn Bechtel (daughter) 21122 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1629 Undifferentiated Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/27, 1983, to 5/28, 1983, that (I) (we) lost
saw the deceased alive on MAY 27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
P. Konits | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PHILIP H. KONITS, M.D. | | 22e. ADDRESS
615 HAMMONDS LANE
BALTIMORE, MARYLAND 21225 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
June 1, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Vet. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY
Crownsville Anne Arundel Md. | |
| 24. FUNERAL DIRECTOR
NAME
Mc Cully Funeral Home of Pasadena
Mountain and Tick Neck Rds. Pasadena, Md. 21122 | | 25a. DATE REC'D. BY REGISTRAR
JUN 2 1983 | | | |
| | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 1 9 0 8

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|---|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edna Mary Warren | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 14, 1983 | | | 2b. HOUR
1:00 A M | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 28, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Harmans | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7606 Harmans Rd. Hanover Md. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY
Pvt. Family | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
AA Co. | | 13c. CITY OR TOWN
Harmans | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
21076 Md.
7606 Harmans Rd. Hanover | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Green | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rachel Green | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF KNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
220-22-7346 | | 17. INFORMANT
ADDRESS Hanover, Md 21076
Doris Long-7151 Wright Rd. | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u>
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of Breast</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 19a. DATE OF OPERATION
1/13/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of Breast | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Dec. 30, 1982</u> to <u>Present</u> , the (1) (we) last saw the deceased alive on <u>5/10, 1983</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Colvin C. Carter, MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Colvin C. Carter, MD | | | | 22e. ADDRESS
4700 Pennington Ave. Baltimore Md 21226 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
5/20/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. Maryland | |

| | | | | | |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Herbert E. Miller - 3035 W. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 23 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carter | |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/76

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 | | | | | | | | | | REG. NO. 11909 | |
|--|---------------------|---|---|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Frederick Michael Wengert | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 2b. HOUR OF ESTIMATED DEATH
MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 1983 2323 M | |
| 3. SEX
m | 4. RACE
w | 5. DATE OF BIRTH
MONTH 12 DAY 02 YEAR 1969 | 6. AGE (IN YEARS)
LAST BIRTHDAY 69 YRS. | IF UNDER 1 YR.
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
MONTH 5 DAY 28 YEAR 1983 | | 2d. HOUR
1159 M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter | | 12b. KIND OF BUSINESS OR INDUSTRY
Home Imp. | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
PADEN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
130 Chavel Beach Rd. (21226) | | | |
| 14. FATHER'S NAME
FIRST Michael MIDDLE Wengert LAST Wengert | | | | 15. MOTHER'S MAIDEN NAME
FIRST Elizabeth MIDDLE Hidgon LAST Hidgon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-10-7765 | | 17. INFORMANT
ADDRESS
Bessie Wengert (same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE George E. Linhardt | | | | TITLE (SPECIFY)
Dep | | | | DATE SIGNED 5/29/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
George E. LINHARDT JR. | | | | ADDRESS
312 Washington St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
6/1/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME Balto., Md. 21225
George J. Gonce F.H. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 01 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Gonce | | | |

MEDICAL CERTIFICATION

1. *Abstract*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VRA 15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11910 | |
|---|--|---------------------|--|---|--|---|--|--|---------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Kimball Mansfield Wheet SR | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | MONTH DAY YEAR 5 4 19 83 | | 2b. HOUR MIN 530 | |
| 3. SEX Male | | 4. RACE Cauc | | 5. DATE OF BIRTH
MONTH DAY YEAR 11 03 22 60 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 60 | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel | |
| 10. CITY OR TOWN OF DEATH Riva | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 110 Woodside Road 21140 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NAVY | | 12b. KIND OF BUSINESS OR INDUSTRY RETIRED | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STATE Maryland | | 13b. CITY OR TOWN Anne Arundel Riva | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST William Layton Wheet | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Bertie Ann Bishop | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WW 11 314-12-6975 | | 17. INFORMANT 21666 ADDRESS 109 S.C. Rd. Stevensville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) Essential Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) Hemorrhoids | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min.
5 years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Richard E. Cook | | | | | | TITLE (SPECIFY) Sub. Dep. | | | DATE SIGNED 5/4/83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Richard E. Cook | | | | | | ADDRESS 113 Cathedral St., Annap., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL | | | | 23b. DATE 5-7-83 | | 23c. NAME OF CEMETERY OR CREMATORY HILLCRIST Cem. | | | | 23d. LOCATION
CITY OR TOWN STATE ANNAPOLIS AR. MD. | |
| 24. FUNERAL DIRECTOR
NAME Taylor Funeral Chapel ADDRESS 21401 Annapolis MD | | | | | | 25a. DATE RECD. BY REGISTRAR MAY 9 1983 REGISTRAR'S SIGNATURE John J. Smith | | | | | |

MEDICAL CERTIFICATION

RECEIVED
JAN 12 1983
X

PAID
JAN 12 1983
JAN 12 1983
JAN 12 1983

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3 (REMAIN PAGE 5 FOR FUNERAL DIRECTOR). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

11911

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---------------------|--|--|---------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
JAMES | | | MIDDLE
A | | | LAST
WHITCOMB | | | 2a. DATE KNOWN OF DEATH
ESTIMATED | | | MONTH
5 | | | DAY
28 | | | YEAR
1983 | | | 2b. HOUR
M | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
MONTH DAY YEAR
8-4-66 | | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
16 YRS. | | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
5 28 1983 | | | 24 HOUR
2:37 a M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
STUDENT | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
HIGH School | | | | | | | | |
| 13a. STATE
md | | | 13b. COUNTY
AA | | | 13c. CITY OR TOWN
PASADENA | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
21122
716 BIRCH AVENUE | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
(TYPE OR PRINT) | | | FIRST
JAMES | | | MIDDLE
A | | | LAST
WHITCOMB JR. | | | 15. MOTHER'S MAIDEN NAME
(TYPE OR PRINT) | | | FIRST
Lillian | | | MIDDLE
DANIELS | | | LAST
DANIELS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
— | | | 17. INFORMANT
ADDRESS
JAMES A. WHITCOMB JR - ABOVE. | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
8147
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12:42xx 5-28-1983 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Pedestrian struck by auto. | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | | | | | 21f. LOCATION
STREET
Rt. 2
CITY OR TOWN
Anne Arundel
COUNTY
Md.
STATE
Md. | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Ann M. Dixon | | | | | | TITLE (SPECIFY)
M.D. Assistant | | | | | | DATE SIGNED
5-29-83 | | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | | | | | 23b. DATE
5/31/83 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cem. | | | | | | 23d. LOCATION
CITY OR TOWN
Glen Burnie
COUNTY
AA
STATE
md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
John S. Baranack | | | | | | ADDRESS
Severna Pk. Ind | | | | | | 25. DATE REC'D. BY REGISTRAR
JUN 3 1983 | | | | | | 25. REGISTRAR'S SIGNATURE
John J. Canine | | | | | | | | |

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RECEIVED

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Items #2a, 18-22a Film G580 6/16/83 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11912

| | | | | | | | |
|---|-------------------------|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Eleanor Williams | | | | 2a. DATE KNOWN OF DEATH
MONTH 5 DAY 7th YEAR 1983 | | 2b. HOUR M | |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH 6 DAY 28 YEAR 51 | 6. AGE (IN YEARS)
LAST BIRTHDAY 30 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 HOURS 0 MIN. | 7c. DATE PRONOUNCED DEAD
MONTH 5 DAY 9 YEAR 1983 | 7d. HOUR 3:42 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
woods-Arundel on the Bay | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MARYLAND | | 13b. CITY OR TOWN
A.A. | 13c. CITY OR TOWN
ANNAPOLIS | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
702 E. Newtown Drive 21401 | | |
| 14. FATHER'S NAME
FIRST GEORGE MIDDLE WILLIAMS LAST WILLIAMS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MARTHA MIDDLE SIMMS LAST SIMMS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Md. 21401 PHILIP HARRIS 706 B Newtown Dr. Annapolis | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: Stab wound of chest
9660
IMMEDIATE CAUSE (a) 9660
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. 10:00 MONTH 5 DAY 7 YEAR 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject stabbed | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
woods | | 21f. LOCATION
STREET Arundel on the Bay CITY OR TOWN Anne Arundel Co. COUNTY Md. STATE Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED 5-11-83 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS 111 Penn Street, Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5-14-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
CHEWS CHURCH CEMETERY | | 23d. LOCATION
CITY OR TOWN Owensville COUNTY A.A. STATE Maryland | |
| 24. FUNERAL DIRECTOR
NAME WILLIAM REESE & SONS MORTUARY, P.A. ADDRESS Annapolis, Md. 21401 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 16 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carver</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C. 20315



DATE: 10 1 1960

TO: THE SECRETARY OF THE ARMY

FROM: THE CHIEF OF STAFF

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

MAY 1960

100-100000-100000
100-100000-100000
100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 1 1 9 1 3
REG. NO. | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELLA WILLIAMS | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 30 83 | | | | 2b. HOUR
11 37 P.M. | | | | | |
| 3. SEX
Female | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 1 90 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD-USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
CROFTON MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CROFTON COMU-CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
Domestic | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
LINTHICUM | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
21090
606 SHIPLEY ROAD | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANDREW DAUMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELENA Shutz | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-50-7299 | | 17. INFORMANT
ADDRESS
ALICE VIELMEYER OGt SAME | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4409 left ventricular failure
DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (c) cerebral arteriosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Months
Months
years | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/30 19 83 to 5/30 19 83, that (I) (we) last saw the deceased alive on 5/30 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Me Frank | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/31/83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MAX C FRANK MD | | | | 22e. ADDRESS
7575 Ritchie Hwy
Green Spring MD 21061 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/2/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Homes | | | | 24b. ADDRESS
Baltimore, Md., 21225
237 E. Patapsco Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 2 1983 | | | | 25b. REGISTRAR'S SIGNATURE
J. J. Conner | |

BP

100%

100%



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 3 11 9 1 4
REG. NO. |
|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Elsie West Williams | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 5 83 | |
| 3. SEX
female | | | 7b. HOUR
7:34 A.M. | |
| 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 17, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Laurel Fork, Va | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
A.A. Co. | | 12b. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Postmaster |
| 13c. CITY OR TOWN
West River | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
332 Owensville Rd. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Walter Webb | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Corä Eddie Marshall | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
215-28-0601 | | 17. INFORMANT
ADDRESS
Priscilla Baker P.O. Box 326 Edgewater, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
1579 IMMEDIATE CAUSE (a) Carcinoma of the pancreas
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/8 , 19 83 , to 5/5 , 19 83 , that (I) (we) lost
saw the deceased alive on 5/8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death. | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/5/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/9/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery Arlington Va. |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Va. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | ADDRESS
12 Rigely Ave Annapolis MD | | 25a. DATE REC'D. BY REGISTRAR
MAY 6 1983 |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |



Handwritten text at the bottom left, possibly a signature or date, including the words "Handwritten" and "Date".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11915 | | | |
|--|--|----------------------|--|--|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) Carroll Wills | | | | | | | | | | DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5/15/83 | | 2b. HOUR 9:25 | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 28 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD 5/15/83 | | 7d. HOUR A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Dunkirk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 20754 Rt. 1, Box 417 Mckendree Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sollers Wills | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Estep | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. WW2 | | 17. INFORMANT Idabel M. Wills | | | | ADDRESS Box 417 Dunkirk, Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: 4292 Arteriosclerotic cardiovascular disease
IMMEDIATE CAUSE (a) 4292
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Body Only
DUE TO, OR AS A CONSEQUENCE OF
(c) Body Only | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Body Only | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margaret A. Korell | | | | M.D. Assistant | | | | DATE SIGNED 5/16/83 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE May 20-83 | | 23c. NAME OF CEMETERY OR CREMATORY Moses Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lothian Anne Arundel Md | | | |
| 24. FUNERAL DIRECTOR NAME Spencer E. Sewell | | | | | | ADDRESS Box 31, Prince Frederick, Md | | | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Canale | |

1945 10 10

USA

1945

1945 10 10

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1945 10 10

1945 10 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 83 11916
REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Winchell Homer Best Winchell | | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 3 1983 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug 11 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MO | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Severna Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Meridian Nursing Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Prof. language | | 12b. KIND OF BUSINESS OR INDUSTRY
Civil Service | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Severna Park | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Frederick Winchell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaretta Best | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
220-44-6214 | |
| 17. INFORMANT
Mary M. Winchell | | 18. ADDRESS
Same as #13 | | 19. DATE OF OPERATION
4-3-83 | | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED
Arteriosclerotic Cerebrovascular Disease | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4370 IMMEDIATE CAUSE (a) | | 21. DUE TO, OR AS A CONSEQUENCE OF
(b) | | 22. DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic upper G.I. bleedings, Chronic anemia. | | | | | | | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 23b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 23d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 24a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 24b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 24c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 24d. DATE SIGNED | |
| 25a. I certify that (1) (this hospital) attended the deceased from 4-7-83 to 5-3-83 , that (1) (we) lost 4-7-83 saw the deceased 4-7-83 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated | | 25b. DEGREE
Arnold G. Alexander, MD | | 25c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 25d. DATE SIGNED | |
| 26a. PHYSICIAN'S NAME (TYPE OR PRINT)
Arnold G. Alexander, M.D. | | 26b. ADDRESS
650 Ritchie Highway, Severna Park, MD | | 26c. NAME OF CEMETERY OR CREMATORY
Et. Lincoln | | 26d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. MD | |
| 27a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 27b. DATE
May 4, 1983 | | 27c. NAME OF CEMETERY OR CREMATORY
Et. Lincoln | | 27d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. MD | |
| 28. FUNERAL DIRECTOR
NAME ADDRESS
Taylor Funeral Chapel - Annapolis, MD | | 29. DATE REC'D. BY REGISTRAR
MAY 9 1983 | | 30. REGISTRAR'S SIGNATURE
John J. Givens | | 31. REGISTRAR'S SIGNATURE | |

BP _____

8-2-32

with Homer Best (Circular)
 Under the flag in 1882
 USA
 Home Hospital
 General Hospital
 A. A. Secord
 Charles F. Secord
 Mary M. Secord
 Mrs. Secord



This is the only one
 X

8-2-32
 X
 8-2-32

Taylor General Hospital
 General Hospital
 General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 1B show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 83 | 11917 | | |
|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| MARIE A. WINKLER | | | | 5 25 83 | | 1 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| female | white | May 11, 1894 | | 89 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | USA | | | Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Glen Burnie | Maryland Manor Nursing Home | | | seamstress | | factory | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | | | |
| Maryland | Baltimore | Baltimore | | 1933 Hollins Street 21223 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| | | Octien | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| no | | 220-05-5173 | | Mrs. Helen Brankovich 1211 June Road 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4280 C.H.F.
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-18, 1977, to 5-25, 1983, that (I) (we) lost saw the deceased alive on 4-6, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
DEGREE | | 22c. DATE SIGNED | | | |
| DR. Michael Pearlman | | | | 5-25-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| DR. Michael Pearlman | | 5400 OLD Court Road
Randallstown Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| burial | | 5/27/83 | Loudon Park Cemetery | | Baltimore City Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE RECD BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Ambrose Funeral Home 1328 Sulphur Spring Rd. | | MAY 25 1983 | | John J. Conner | | | |

BP

Mar 11 1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11918 | |
|--|--|------------------|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JOSEPH HENRY WOLF | | | | | | | | | | 2a. DATE KNOWN OF DEATH
5-7-83 19 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Aug. 24, 1915 67 YRS. | | 6. AGE (IN YEARS)
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
5-7-83 19 | | 7d. HOUR
9AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Inspector-Dept. Agricult. | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | | | | | | | 13b. COUNTY
Anne Arundel | |
| 13c. CITY OR TOWN
Pasadena | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS
128 Wileys Lane | | | | | | | | | | 21122 | |
| 14. FATHER'S NAME
Christian | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
Rachel Kozign | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW 2 | | | | | | | | | | 16b. SOCIAL SECURITY NO.
063-03-9245 | |
| 17. INFORMANT
Mrs. Vivian Wolf | | | | | | | | | | ADDRESS
Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8120 IMMEDIATE CAUSE (a) Multiple injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 19c. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 20b. TIME OF INJURY
8AM A.M. MONTH DAY YEAR
P.M. 5-7-83 19 | |
| 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver of auto/auto collision | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
intersection | |
| 20f. LOCATION
Moutain Rd. & Hickory Pt. Rd. Anne Arundel Co. Maryland | | | | | | | | | | | |
| 21a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell, M.D. | | | | | | | | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | | | | | | | DATE SIGNED
5-8-83 | |
| ADDRESS
111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | | | | | | 23b. DATE
5/10/83 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn Cemetery | | | | | | | | | | 23d. LOCATION
Marriottsville COUNTY Md. | |
| 24. FUNERAL DIRECTOR
Leroy M. & Russell C. Witke Funeral Homes P.A.
1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 10 1983 | |
| 25b. REGISTRAR'S SIGNATURE
John G. Conner | | | | | | | | | | | |



RECEIVED
JUN 11 1964



Handwritten signature

RETURNED BY: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by _____
TO FUG: hospital or attending physician.
sh: _____

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

83 11919

| | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|-------------------------------|--|-----------------|--|-----------------|--|-------|--|----------|--|------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | MIN. | |
| Jennie Thomas Yendell | | | | | | | | 5-15-83 | | | | | | | | 3:45 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 74 HRS | | | | | | | |
| F | | W | | 10-12-1890 | | 92 | | | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Rye N.Y. | | USA | | | | Anne Arundel Co. | | | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Annapolis | | Anne Arundel General Hosp. | | rental agent | | self employed | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Md. | | A.A. Co. | | Shady Side, Md. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1410 East West Shady Side Rd. | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Charles | | Thomas | | Jane | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| no | | 579-24-7048 | | Jane Busch | | 1410 East West Shady Side Rd.
Shady Side, Md. 20764 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CVA</u>
<u>4360</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>ATHEROSCLEROTIC VASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>years</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>7 d</u> | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>DET</u> , 19 <u>76</u> , to <u>MAY 15</u> , 19 <u>83</u> that (I) (we) last
saw the deceased alive on <u>5/14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23a. SIGNATURE
<u>Harvey J. Steinfeld</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF
DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 23b. DATE SIGNED
<u>5/17/83</u> | | | | | | | | | | | | | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>HARVEY J STEINFELD</u> | | 23d. ADDRESS
<u>SHADYSIDE, MD. 20764</u> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| Cremation | | 5/18/83 | | Westview Crematory | | Baltimore, Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Indestry Funeral Home | | 12 Ridgely Ave. Ann. Md. | | MAY 18 1983 | | <u>[Signature]</u> | | | | | | | | | | | | | |

Wm. J. ...

Handwritten notes and signatures, including "Wm. J. ...".

Handwritten notes, including "CVA" and "B...".

Handwritten notes and signatures, including "T. J. ...".

Handwritten notes and signatures, including "T. J. ...".